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MODERN TRENDS IN PSYCHIATRY*

BY WINFRED OVERHOLSER, M. D., Sc.D.

It is an honor and a privilege indeed to be selected as the first Richard H. Hutchings Memorial Lecturer. Many of this audience, like myself, had the pleasure of knowing Dr. Hutchings personally; all who came in contact with him admired, respected and loved him. During his lifetime, which extended from 1869 to 1947, he not only witnessed a great advance in the field of psychiatry but was himself a part of it. Entering the New York State service at St. Lawrence State Hospital in 1892, he served continuously for the astonishing period of 47 years, 20 of those years as the superintendent of the Utica State Hospital. He established the first regular state hospital out-patient department in 1909; he experimented with music therapy and was one of those who very early recognized the value of the contributions of Sigmund Freud. He was not only a competent and progressive state hospital administrator; he taught at the College of Medicine of Syracuse University from 1908 to 1931, where an undergraduate society was named in his honor, and he served for many years as the editor of THE PSYCHIATRIC QUARTERLY, a journal which ranks among the highest in its field. His contributions to the field of psychiatry were recognized by his election in 1938 as president of the American Psychiatric Association. Always progressive, ready to accept the new and promising, kindly and considerate, he was a true southern gentleman, an outstanding psychiatrist and to the very last a refutation of the notion that age is synonymous with impenetrability to new ideas.

The history of psychiatric thought indicates that, just as in other fields, progress has rarely been made in a straight line. Particularly in the field of therapeutics, various methods have been tried, and some of them have earned their place, the pendulum now swinging toward the psychological, now toward the physiological approach. Certain it is that with all of the emphases, enthusiasms

*The first Richard H. Hutchings Memorial Lecture given at Syracuse, N. Y., October 3, 1949. (Richard H. Hutchings, M. D., deceased October 28, 1947, was a past president of the American Psychiatric Association, and former superintendent of St. Lawrence and Utica [N. Y.] State Hospitals. He was professor emeritus of clinical psychiatry at the College of Medicine of Syracuse University and editor of this QUARTERLY at the time of his death. A series of annual lectures is being given at Syracuse, N. Y., as a memorial to him.

and extravagant claims no panacea yet exists. Perhaps a brief review of some of the highlights of psychiatric progress may illustrate these points.

Psychiatry as a specialty of medicine is usually considered to have been set apart by Pinel in 1801 with the publication of his *Medico-Psychological Treatise on Mental Diseases.* He was certainly one of the first physicians to deal with this problem as a medical specialty. Before his time, mental disease had been discussed largely by philosophers or the clergy, and had been looked upon as something quite apart from the general field of medicine. It seems appropriate here, however, to mention a predecessor of Pinel, an Italian who, for some reason, has escaped mention in most of the books dealing with the history of psychiatry.

He was Vincenzo Chiarugi, born at Empoli, Italy, on February 20, 1759.* He was a student of the famous Morgagni, and in 1782 became assistant physician at the Hospital of Santa Maria Novella in Florence. He was fortunate to work under the auspices of the Grand Duke of Tuscany, a man who was broad-minded, progressive and humane, and who had enacted legislation concerning the care of the mentally ill as early as 1774. One of Chiarugi's first acts was to abolish physical punishment and chains and to make regulations concerning the humane care of the patients in the hospital. In 1793, eight years before the publication of Pinel's work, he published a three-volume work, *Insanity in General and in Particular,* which thus may be considered the first systematic treatise by a medical man on the subject of mental disease. He interpreted mental disorder as due to brain damage; he anticipated the Kraepelinian concept of manic-depressive psychosis and gave an early description of general paresis, noting among other things the rigidity of the pupil in that disease.

There is no evidence that Pinel had any knowledge of the work of Chiarugi, even though Italy was not far away from France, nor is mention of Chiarugi intended to detract at all from Pinel's contribution. Indeed for the western world, Pinel remains the father of psychiatry as a medical specialty. The coincidence, for it was essentially that, is merely another striking indication of the fact that at various points in history men who were ahead of their times have independently and simultaneously hit upon some idea

*I am indebted for this information to my friend, Dr. Carlo de Sanctis of Rome, Italy.

of progress. It should be borne in mind, for example, that Tuke established the York Retreat in England at almost exactly the same time that Pinel was effecting his reforms at the Salpêtrière. The history of the controversy over the discovery of the anesthetic properties of ether in this country is another case in point. Actually, of course, in Pinel's day a ferment was at work all through Europe and, indeed, through the western world, which culminated politically in the American and French Revolutions. Emphasis was being given to the dignity of man and to the individual's right to humane care.

Pinel and his successors, Georget, Esquirol and Falret, for example, were like Chiarugi, sound observers as well as humanitarians. Pinel, especially, emphasized what he referred to as moral treatment, or as we should say today, psychotherapy, and the value of kindness, freedom from restraint, pleasant surroundings, sympathy, music and, in particular, occupation. On the other hand, Pinel's nearest American contemporary and America's first psychiatrist, Benjamin Rush, viewed mental disease as due to a "determination of blood to the brain." Following the materialistic teachings of his Scottish teacher Cullen, he advocated bleeding, vomiting, purging, and even threats of death. There is some indication, indeed, that Rush was not entirely averse to the use of chains, although he appears to have deprecated the use of what he refers to as "the lash." Two of his inventions, the "tranquilizer" and the "gyrator," certainly may be classified as an early form of "shock therapy." Parenthetically it may be remarked that although Rush's volume, *Medical Inquiries and Observations Upon the Diseases of the Mind,* published in 1812, is often referred to as the first American textbook on psychiatry, at least two earlier books were published in this country, although written by Englishmen. One was Trotter's little volume on *The Nervous Temperament,* reprinted in Troy in 1808, and the other was Cox's *Practical Observations on Insanity,* reprinted from the second London edition in Philadelphia in 1811. Incidentally, Cox's volume advocates far more humane treatment than does Rush's somewhat slightly later one. There is no question, however, that Rush's volume was the first textbook on mental disorders written in this country by an American.

In the year 1778, when Pinel came to Paris, another very interesting figure likewise arrived on the Parisian scene, one Anton Mesmer, whose activities gave rise to acrimonious controversy in Paris, and whose influence in one way or another is still with us. Mesmer professed to believe in what he referred to as "animal magnetism." He assumed that there was some sort of mysterious "fluid" which could be, so to speak, focused upon certain persons to bring about certain symptoms or to relieve others. He was in all probability a conscious charlatan, but what he did was to point out at least the importance of suggestion. In his way he has had his influence through the years on the psychotherapeutic approach as opposed to the neurological. Charcot's work on hypnotism was an outgrowth from Mesmer, for example. Another of a different sort was the influence of a "magnetizer" on P. P. Quimby, one of the inspirers of Christian Science. Unfortunately, mesmerism and its close affiliate, hypnotism, have suffered much by the aura of quackery which has surrounded them, and it is only recently that hypnotism has achieved recognition as a valuable weapon in the therapeutic armamentarium of psychiatry.

The early years of the nineteenth century saw the activities of Gall and Spurzheim, the founders of the school of phrenology. At this distance in time, we find it hard to appreciate what a tremendous vogue this school had for a period of considerably over 50 years, both on the continent, in the British Isles and in this country. There were phrenological clubs, phrenological journals and various volumes treating of the phrenological approach to human behavior. The fundamental thesis of this cult was that certain functions of the personality are localized in certain parts of the brain and that the excess or deficiency of a given function (or in phrenological jargon "organ") is manifested by a corresponding protuberance or depression of the portion of the skull overlying that portion of the brain. Phrenologists, therefore, by determining the "bumps and dents," professed to be able to diagnose the personal excellences and deficiencies of the individual. The important contribution of phrenology lies in its emphasis upon cerebral localization. Gall and Spurzheim were honest men and sincere workers, though misguided, and their work gave a tremendous stimulus to the development of what is referred to as the German school of neurology, with its interest in the physiology and

anatomy of the central nervous system.* The German writers on psychiatry, following the period of these workers, tended to be neurological in approach as, for example, Griesinger, whose *Mental Pathology and Therapeutics* was published in 1845.

There were other approaches, however. In 1838 Nasse and Jacobi wrote several articles in which the term "psychosomatic medicine" was introduced. Nasse stated the principle as follows: "The business of recognizing, treating, and preventing conditions of mental disorder rests upon the fundamental investigation of the simultaneously psychic and somatic activity of man. Here it finds its scientific support, from here on it gains light and learns the road."** This concept seems not to have made a very profound impression at the time, and for the better part of 100 years even the phraseology lay dormant until its recent re-discovery.

While French psychiatry was following the principles of "moral treatment" and German psychiatry was developing along the lines of a neurological approach, such psychiatry as was being practised in the United States was almost entirely limited to the state hospitals, except for what the neurologists were doing with the static spark and with Weir Mitchell's "rest treatment." It is significant that from the time of Rush until practically the end of the century the only two textbooks on mental disorder published in the United States were written by neurologists, Spitzka and Hammond. In the state hospitals the trend appears to have been, so far as any treatment at all was practised, along the lines of hydrotherapy, occupational therapy, and recreation, that is, "moral treatment." The therapeutic results were hardly outstanding. Occasional interest was given to prevention; at least Sweetser in 1842 wrote his volume on *Mental Hygiene,* a term which fell into disuse until it was suggested to Clifford Beers by Adolf Meyer in 1908. The formulations of Kraepelin, beginning in the 80's, found a ready hearing in psychiatric circles in this country, although their emphasis on treatment was quite secondary. Kraepelin's great contribution was in the field of description and classification; he was essentially fatalistic about treatment.

*See, for an example of Spurzheim's anatomical studies: *Anatomy of the Brain,* tr. by R. Willis, London, 1826. For his views on mental disease in general, see his: *Observations on the Deranged Manifestation of the Mind, or Insanity,* London, 1817.

**Ztschr. f. d. Beurteilung u. Heilung der krankhaften Seelenzustände, 1:1 (Berlin, 1838).

It seems hard to realize that Freud and Kraepelin were essentially contemporaries, for Freud's influence became strong in the United States far later than did that of his German fellow-psychiatrist. It was, indeed, not until about 1908 that Freud's writings became known in this country through Brill's translations. There was great resistance in the early days, but thanks largely to the support of Smith Ely Jelliffe and of William A. White much of the early opposition was overcome, so that today we find that Freudian formulations have permeated the whole of psychiatric thinking. White's lucid formulation of the "organism as a whole" finds, indeed, general acceptance today. During the same period the psychobiological formulations of Adolf Meyer were being promulgated; they attracted great attention and support because of their interpretation of mental phenomena as merely one aspect of biological functioning rather than as something quite distinct and apart. Here was an approach which could be understood by the general physician. Meyer's contributions to psychiatric philosophy are still gaining in influence.

In another field, but contemporaneously, we should mention the work of Clifford Beers, the father of the mental hygiene movement. Beginning in 1908 as a protest against state hospital neglect, the mental hygiene movement spread rapidly into the field of prevention. The child guidance movement, closely related, originally dates from Healy's work in Chicago beginning in 1912; it was further developed by Thom, Lowrey and Plant, and has long since achieved great significance.

In 1917 the United States entered World War I. Interestingly enough, although psychiatry was then nowhere nearly so well developed as a specialty as it was in 1941, it was recognized far more promptly as an important aspect of the medical care of troops. Perhaps the most significant contribution of this period was a widespread recognition of the importance of the neuroses and their treatability and curability. Up until that time, with the exception of the relatively few private practitioners of psychoanalysis, and the somewhat more numerous neurologists, relatively little attention had been paid to the neuroses. There was such a wide incidence of what was then known as "shell-shock" in the services, however, that not only the medical profession but a large segment of the public learned that the neuroses are treatable.

During the period of World War I, Wagner-Jauregg was working in Vienna on the malarial treatment of general paresis, a treatment first employed in this country at Saint Elizabeths Hospital under William A. White in 1922—perhaps the most significant advance in the treatment of mental disorders which had until then been made in this century. During this period and shortly afterward as well, Sherrington, Cannon, Adrian and others were doing their important work on the autonomic nervous system and pointing the way for the development of what is now generally, and indeed popularly, known as "psychosomatic medicine." Whether this is properly a specialty of psychiatry is an open question. I am inclined to think that it belongs in the field of internal medicine instead, and certainly the aim of psychiatrists should be to emphasize to all practitioners of medicine the important relationships between the physiological and the psychological. The term has come, and erroneously, to mean roughly the equivalent of neurotic, that is, emphasis is too often laid upon the causation of physical symptoms by psychological mechanisms, whereas the reverse is often overlooked.*

An outgrowth of psychosomatic medicine, if we must use that unfortunate term ("comprehensive medicine" seems less objectionable), has been the development of psychiatric wards in general hospitals and a closer rapport between psychiatry and general medicine. The Pennsylvania Hospital and the New York Hospital had mental patients in their general wards in the middle and later 1700's, subsequently setting up entirely separate departments. The modern trend in this direction was set by the Albany Hospital in opening a psychiatric pavilion as early as 1902, and today the practice is for almost all but the smallest general hospitals to have psychiatric facilities. Certainly if a hospital is to deserve the name of "general" it should be prepared to see the patient through, regardless of the nature of his original or intercurrent symptoms.

Since about 1920 there has been a rapidly growing interest in psychoanalysis and in various developments of the work of Freud and his former associates, Adler, Jung and Stekel. Although individual psychotherapy has for obvious reasons not been widely used in mental hospitals, there has been a rapidly increasing demand for it in private practice, particularly in dealing with the neuroses. In the field of psychologic therapy, however, there is a

*On this point see editorial comment: N. E. J. Med., 236-83, January 9, 1947.

characteristically American development which offers much promise, namely, group psychotherapy.

Some of the very early work in this field was started by Joseph H. Pratt in Boston as early as 1906 in connection with tuberculosis patients; he gradually extended it to include various neurotic disturbances. The term itself was coined by J. L. Moreno in 1932 (Moreno attributes the first use of the term "psychotherapy" to Reil in his "Rhapsodies" in 1803) when a symposium was held at the meeting of the American Psychiatric Association in Philadelphia under the chairmanship of William A. White. The development by Moreno of the special form of group psychotherapy known as psychodrama is well known to all, and today we find this particular type receiving wide attention.* There are, of course, many other forms of group therapy which have been developed by Moreno, Slavson and others, and much is being done in various mental hospitals at the present time in the application of this technique. As a practical matter it enables the psychiatrist to give his attention simultaneously to a number of patients, thus for practical purposes multiplying the therapist. There are, too, important impacts of the group upon any individual member of it.

In the field of psychiatry, both theoretical and therapeutic, there have been numerous other developments which can only be mentioned in passing. The contributions of Harry Stack Sullivan, particularly in the field of interpersonal relations and in regard to the relationship of psychiatry to anthropology and sociology, have widened the scope of psychiatric interest materially. Alexander and French have developed briefer methods of psychotherapy, something which is greatly needed if individual psychotherapy is to be useful to a large number of persons, while Karen Horney has emphasized the importance of the social factors in the development of the psychoses and neuroses.

Until the middle 1930's the stress in mental hospitals was almost entirely on the psychotherapeutic approach and its auxiliaries, such as occupational therapy. In private practice as well, individual psychotherapy was the rule. About that time a new approach came on the scene, namely the pharmacologic and electrical. First among these new methods, was Sakel's insulin shock therapy, to be followed soon thereafter by Meduna's metra-

*See Moreno, J. L.: *Psychodrama*, Vol. 1, New York, 1946; *Group Therapy: A Symposium*, New York, 1945.

zol therapy and the electric shock treatment of Bini and Cerletti. The idea of shock as therapy is, of course, not a new one. It is of some interest indeed to note that as far back as 1785 one William Oliver reported in the *London Medical Journal* the cure of a case of mental disorder (apparently a manic episode) after the patient had suffered convulsions caused by a substantial dose (two scruples) of camphor; convulsive therapy* is not a novelty! The pharmacologic and electrical approach interested many workers in view of the then prevailing pessimism regarding the therapeutic possibilities in schizophrenia, and there has been a wide vogue of these forms of treatment, a vogue in which enthusiasm and exaggerated claims have all too often been substituted for scientific evaluation.

The public in general, and indeed the general run of the medical profession, had been prone to look with some suspicion upon the "intangible" approach of psychotherapy. It was a fact, too, that a good many of the patients subjected to psychotherapy, or "expectant treatment," did not appear to respond, at least with any degree of promptness. For that reason there was a very ready acceptance of forms of treatment which constituted "doing something for the patient." That they were doing something *to* the patient, there was no question whatever! The comas and the convulsions offered visible evidence that something was going on. Electric shock therapy particularly—administered by the use of a small and readily portable apparatus—appealed to the untrained; there are still too many alleged psychiatrists, the extent of whose therapeutic knowledge is locked up in their little black box. Nevertheless, with all of the possible risks of damage to the brain tissue, with all of the fractures, dislocations and ruptured intervertebral discs, there is no question that shock therapies have shortened the course of many a depression. The results in schizophrenia have not been so promising as was originally hoped, although there are still enthusiastic adherents, especially of insulin shock, in this disorder. During World War II, especially in England, it was found that Sargant and Slater's "subshock insulin" was very helpful in certain of the acute anxiety states. Some experimentation has been done too with histamine and with other drugs which pro-

*An interesting account (1682) of recovery from "frenzy" following the transfusion of incompatible blood is presented by A. B. Siewers in: Bull. Inst. Hist. Med., 6:1010; No. 9, November 1938.

duce relatively violent physiological shock changes. One advantage of this type of treatment in general is that it has, by emphasizing the physical aspects, brought general medicine closer to psychiatry.

An interesting chapter in therapy might be written concerning the so-called sodium amytal interview, narcoanalysis or narcosynthesis. As far back as 1930 Lorenz and Bleckwenn demonstrated the value of sub-narcotic doses of intravenous sodium amytal as a means of a quick approach to unconscious material. Their contribution was apparently largely forgotten in a good many quarters until during World War II it was resuscitated and rechristened. There seems to be no question of the value of this pharmacological adjunct in psychotherapy, especially in acute disorders such as are found during war. It is perhaps of somewhat less value in civilian practice. Another use of narcotic drugs, namely the "prolonged sleep" treatment of Klaesi, has proved to have decided limitations as well as some risks.

Another physical approach of a more destructive nature is represented by what has been termed psychosurgery, that is, prefrontal lobotomy and more recently topectomy. This method has likewise had its enthusiastic adherents and has enjoyed a substantial vogue in certain quarters. It should be emphasized that this is a destructive procedure, permanently depriving the patient of the use of a portion of his brain. It adds nothing, but, on the contrary, subtracts. For that reason it should be considered only as a last resort in cases, particularly those involving a high degree of assaultiveness, aggressiveness or tension, which have run over a long period and have proved resistive to all other forms of therapy. It certainly should not be considered in the early stages of a psychosis or neurosis.

Other physiological and pharmacological studies are being made at the present time. Ashby, for example, has done a considerable amount of work on the distribution of carbonic anhydrase in the brain, while Hyden and others in Sweden have been working upon the function of malononitrile. The endocrine and pharmacologic studies of Hoskins, Hoagland, and Pincus are highly significant. Certainly much information is needed yet upon brain physiology, and these studies should be encouraged and extended, for they offer possibilities of widening our knowledge and our therapeutic abilities. In another field, may be mentioned the work of the Pav-

lovian school as exemplified best in this country by Horsley Gantt. One practical application, the so-called "conditioned reflex" treatment of alcoholism, has attracted considerable attention.

An interesting logical dilemma in attitude toward the so-called drastic therapies is faced at the present time by some of the most enthusiastic adherents of the psychological approach. The psychoanalytic group are prone to decry most violently the drastic therapies, yet they are the very ones who are emphasizing the role of emotions in causing physical symptoms. If there is any truth to the psychosomatic concept, there is equal truth to the somatopsychic, that is, to the fact that physical disorders and abnormal physical states have their effect upon the emotions. There is therefore no reason to assume that alteration in the physical state, whether by drugs, by shock or even by operation may not have its effect, temporary or permanent, on the mental reaction, that is the total reaction of the patient. As Sargant well says, "If these physical treatments also provide the common ground on which psychiatrists and general physicians can walk together again, talk the same language, and so deal better with the public that looms so large in the present practice of medicine, further progress will not be far ahead." Certainly they have done much to eradicate the dualistic concept of "mind" as against "body."

The psychiatrist is a physician. We must expect more and more that the various problems of adjustment will be handled by the internist and the general practitioner rather than by the psychiatrist exclusively. Medical education is undergoing a rapid evolution, and there is a growing integration of psychiatry with the rest of the curriculum, so that the general practitioner of the future will be better fitted to deal with the patient as a whole. There is no doubt today that general medicine needs psychiatry and that psychiatry needs general medicine. It is the physician's duty and obligation to make the diagnosis and to see that the proper treatment is provided. In directing the treatment he may, and very often should, make use of the ancillary disciplines, such as nursing, clinical psychology, psychiatric social work, the clergy. We must not, however, be deluded by talk of partially-trained "doctors of psychiatry" or of turning over the diagnosis as well as the treatment of mental difficulties to even the best trained of clinical psy-

*See Sargant, W., and Slater, E.: Physical Methods of Treatment in Psychiatry. 2d ed. Williams & Wilkins. Baltimore. 1948.

chologists. Psychiatry is still a specialty of medicine, and must remain so.

The types of treatment prescribed have varied, as these fragmentary comments have indicated, through the years. During the century and a half of psychiatry the pendulum of treatment has swung, now toward the psychological, and now toward the physical. At the moment, in spite of the vogue of analysis and other forms of psychotherapy, I think there is definite evidence that the pendulum is swinging now in favor of the physical approach. That it will still swing one way or the other we may be sure, and since this is America we may be sure that the swing of the pendulum, as is usual here in matters medical, social or political, will be a wide one. Recognition is growing that the truth lies not at one extreme or the other, but somewhere between the two, that neither the psychological nor physiological possibilities must be overlooked in diagnosis and treatment. The pendulum should never come entirely to rest, for that means cessation of progress, but we may safely expect that there eventually will be a stabilization, a fusion of the points of view such as Jules Masserman has attempted so well in his *Principles of Dynamic Psychiatry*,* and that eventually we may have, so to speak, a non-partisan, a truly catholic, a universal psychiatry. No psychiatrists, no group of psychiatrists have all the answers, and there are many obscure areas still which call for more and more research, more personnel, closer co-operation between the hospital and the clinic. It behooves us all to be charitable and open-minded, ready to accept whatever promises to be helpful to one patient without being unduly harmful or threatening, regardless of -isms and dogmas, and hesitant to criticize colleagues who, though perhaps differing from us in their views, may well be fully as intelligent, honest and conscientious as ourselves.

St. Elizabeths Hospital
Washington, D. C.

*W. B. Saunders, Philadelphia, 1946.

FATHER TIME II*

A Continued Analysis of Subjective Conceptions of Time

BY JOOST A. M. MEERLOO, M. D.

I know where time has departed:
Time has departed thither.
From that unaltering country
Never will time turn.

Tawny and still is that country.
Thither is time gone.
Even the air is motionless:
No leaf may fall there.

Time has left me and gone
To that changeless and unchanged country.
Thither has time departed.
There at a day it stands.

You who stood in that country
You may not ruffle your hair:
You may not move nor may even
The scarf slip from you carelessly.

You are caught in the standing of time.
You may not move nor be changed.
Time's past is still:
Time's stillness has taken you.

This is the winter of time:
This is the water frozen:
The oak mute in the wind:
Love's memory motionless.

—*Archibald MacLeish*
in Public Speech.

I. Introduction, time as a relationship.
II. The traumatization of the past.
III. The preparation—or anticipation neurosis.
IV. Timelessness and precognition.

*The author's first paper on this subject, "Father Time," was published in THE PSYCHIATRIC QUARTERLY for October 1948.

I. Introduction

In an earlier study, "Father Time,"[1] the present writer described how past and present are represented in the structure of the human organism, with time-patterns leaving their various imprints as mental and physical engrams. In man's reaction to external events, the past is just as alive in him as his individual personality. Four forms of subjective time experience were also designated, all of them related to a constructive, formative and revolutionary principle. These different concepts of time embrace the states of a gradual development and stem from a primary, biological time sense which in its most primitive phase is able only to recognize a given point on the time-line (i. e., the earth-time).

The gradual evolution of a feeling of time that measures and evaluates segments of the time-line develops secondarily through a confrontation between internal rhythmic functions and external occurrences of an episodic nature. This inner time depends on rhythmic biological processes and its movement is not comparable to the regular movement of physical time. The past is reserved, and man's conception of it is sometimes accelerated, sometimes retarded. The next and higher sense of time—static temporalization—marshals events chronologically along the time-line. This sense of historical succession is expressed in ideas of causality. Finally, the most advanced grasp of time involves the consciousness of dynamic temporalization—duration, process and continuity. Modern man experiences this continuity, e. g., with motion pictures and sound-recording devices, even though the actual physical process is discontinuous.

Our conception of time, which first depends on physiological functions, becomes, at the symbolic level, increasingly related to parental images. Father Time, the symbol of birth and death, is involved in all our ideas of time. In creative activity, time is suspended, we are part of an undifferentiated continuum; "time" is here identical with the process of life. The passage of time symbolizes the period of separation from the mother.[2] Frustration in time always means the missed chance, the missed parental relationship—"too late, too late!"

In this study, the writer will discuss the various ways in which the neurotic uses unconscious time-concepts in structuring his neu-

rosis. We will see how, on one hand, there is a reactivation of earlier experiences, and on the other, an unconscious anticipation and preparation for future occurrences. The neurotic's unconscious yearning for the past invests earlier events with tremendous importance and even the traumatic quality. Of the preparation for future experiences, man is only dimly aware; nevertheless it is analyzable in his immediate behavior at any given time. Especially in those neuroses which the writer has called the *preparation neurosis*,[3] one finds that the traumatic episode is imagined and experienced *before* the traumatic event is provoked.

It is not the intention here to revise existing theory regarding the etiology of neurosis, but rather to emphasize that a more thorough investigation of the relation between man and his time attitudes promises more complete answers to such questions as why early infantile traumata play such an obvious role in the etiology of neuroses and some psychoses. Before presenting clinical material to clarify this point, however, it is necessary to discuss the newer time concepts evolved by twentieth century physics.

Einstein[4] in particular has shown that time cannot be regarded in an absolute sense, flowing from the past to the future. Space is a question of perception, "the order of relations of things among themselves," as Leibnitz said.[5] While it is generally agreed that the concept of space is meaningless unless it includes the idea of things occupying space, there is less recognition that the sense of time is also a modus of perception. It is an order of events, a relationship between occurrences.[6] Einstein points out that the experiences of an individual appear arranged in a series of events: "In this series the single events which we remember appear to be ordered according to the criterion of 'earlier' and 'later.' There exists therefore for the individual an I-time, or subjective time. This in itself is not measurable. I can, indeed, associate numbers with the events, in such a way that a greater number is associated with the later event than with an earlier one. This association I can define by means of a clock by comparing the order of events furnished by the clock with the order of the given series of events. We understand by a clock something which provides events which can be counted.'[7] However, the clocks we use have been geared to our solar system. "What we call an hour is actually a measurement in space—an arc of 15 degrees in the apparent daily rotation of the celestial sphere.'[7]

As laymen, we find it impossible to explore the complicated mathematical foundations of the theory of relativity; for the immediate purpose here it is enough to realize that—again quoting Barnett' ". . . there is no fixed interval of time independent of the system to which it is referred." There is no simple "now," and we can only speak of the "same now" and the "same time" in relation to clocks geared to the same astronomical system. In unrelated systems, we cannot talk of events taking place simultaneously. A similar law is valid for our psychological concepts of time, since they too belong to unrelated systems. A patient analyzing the past—let us say, a traumatic event related to forced weaning—still analyzes the engrams *remaining at the time of analysis*, and not the past event itself. Even in the human being we must seek for different simultaneities, for different "causalities" beside each other, and our task is more complicated because an absolute physical and psychological frame of reference is still lacking. Data and time references in dreams have mostly nothing to do with time conceptions but only with highly charged emotional occurrences behind the dream-screen.[8]

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Biologists and psychologists use numerous anthropocentric word symbols to define the specific activities belonging to life, such as "entelechia," "urge of life," "homeostasis," "horme," "instinct," "*élan vital*," "libido," "autostasia." They are all teleological and finalistic attempts to explain life as a continual drive toward an unknown goal. But the semantic connotation of these terms varies, even though the scientist attempts an exact description of phenomena and their mutual relations. The difference between biologist and physicist is that the former accepts more latitude and spontaneity in the reactions of his subject matter, while the latter is able to reduce his findings to more exact symbolic equations. The two scientists investigate different structures, often without regard to inherently different frames of reference.

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Returning now to the present problem—subjective concepts of past and present—we see that the psychologist who investigates a patient can deal only with actual relations between thoughts and feelings in his patient. Even though a memory be projected into the past, it is a memory *now* and is related to an occurrence and a

symptom *now*—a dream, a conversion, the therapeutic procedure, a thought-association. As the physicist Born[9] has indicated, we may speak only of symmetrical relations, in which there are no causes in the strict sense; and the effect of an earlier experience, the resulting latter event, also may cause the former occurrence. In the psychological investigation of subjective experience, one finds that actual analysis may change impressions from the past; through the therapeutic process, the forgotten and suppressed engram (memory) is brought into awareness, so that the painful cathexis may be eliminated and the event forgotten for good. In the events so investigated, one may speak of a law of reciprocity and mutual dependence of emotional investments (cathexis) between past and present; and we have reason to accept the fact that when a repressed memory engram becomes conscious something has changed with the engram at the moment of recall. We may also say in more analytic terms that the past is traumatized and re-activated in order to fortify the latent fantasy of infantile omnipotence. There exists, in that archaic phase, no time perception, no lost past, but only the magic conception of the immortal unconscious that helps us to conquer the fear of death.

Not enough attention is given to the process of memorization as such, with its curative effect. Memory makes every past event an occurrence of now, it reduces time to zero, it activates the magic idea of omnipotence, that so often seems to be a healing factor, as is experienced in both hypnosis and psychoanalysis.

Although the knowledge of these relations does not influence the therapist's clinical behavior in the case of neurosis, it may affect his theoretical viewpoint and help to explain why so many early traumatic experiences are found in the course of psychoanalytic procedure. In a world full of events many relationships and probabilities exist, and this implies many causes of an actual event in the old sense of the word "cause." The world is not changed or misrepresented by therapeutic emphasis on mutual temporal relationships and possible traumatization of the past by present events—the question is whether we can work with the new hypothesis; and this, only clinical experience will prove.

II. The Traumatization of the Past

The given trend of thoughts may be fortified by our actual clinical experiences of trauma as a temporal event. "It is certainly

true that later experiences can only lead to neurosis if certain biological peculiarities of the mental apparatus are given. But the later actual warding off of the instincts is not explained by being traced back to the first occasion on which instinctual tensions were felt as disagreeable. The neuroses—and this was precisely the discovery made by psychoanalysis—are consequences of these later experiences."[16] The neurosis is often more dependent on the *repetition* of trauma, than it is on the early trauma itself. The primary trauma causes certain conditioning for our memorization—as is needed in the psychoanalytic process—but is not a *conditio sine qua non* for the neurosis. The actual trauma may have mobilized the ancient memory traces (Fenichel); new defense mechanisms may overemphasize the past; or the fear of future dangerous reality is warded off by the fantasy that "it has happened already." In particular, the early death of one of the parents traumatizes the time before that incident. The whole past, before father's or mother's death, changes and acquires a different aspect.

Every trauma upsets the balance between past and future as this balance is represented in our psychosomatic structures. The balance between repressed drives and defenses is disturbed, old mutilation fantasies become aroused, with all their implications: fear of death, castration-fear. Old destructive drives return, primal scenes become emphasized, a general sensitization takes place, and the system of defenses and anticipations is rearranged.

The anxiety involved in the new trauma uses the past as a defense in order to avoid future traumatic experiences.

Case 1

A 22-year-old girl begins psychotherapy because of an acute anxiety syndrome following cerebral concussion. She had always been an active, happy person who carried out her work as a secretary with cheerful enthusiasm until the day she was involved in an automobile accident. On a return home from a party, the car skidded; none of its occupants were badly hurt, but she was taken to the hospital for the treatment of minor cuts and bruises. She was unconscious only for a couple of minutes and she vomited once. After three days (too early) she was dismissed from the hospital.

At home the patient did not rest sufficiently. She complained of headaches, yet wanted to go to work against the advice of her physician. She showed typical postconcussional symptoms of emotional lability—sudden and frequent changes of mood. Three months later the headaches had disappeared, but her mood swings had intensified, and numerous compulsive and neurotic trends had come to the fore. She awakened in panic during the night, she did not dare to set foot outside her house, she became hesitant in all her actions, reversed decisions time and again, doubted her family, and was suspicious of her fiance.

After the ruling out of organic neurological lesions analytic treatment is begun. Aside from furnishing an anamnesis with no conscious extratraumatic material, the patient was not very co-operative for the first few weeks. She had little to say and attributed her present condition to the accident until she brought in her first dream: She was again in a car, but this time as a little girl with her parents. Although she was the oldest of three siblings, none of the other children were there. They rode along a beautiful road, downhill, when suddenly a huge mountain loomed in their path. The car could not stop, everybody screamed, the crash came—and the patient awoke in panic.

When she was asked for associations, she said that she felt "much better now," more controlled. She had told the dream to her parents and asked them if such an accident had actually happened. They denied it, but remembered that in her fifth year, while on a skating trip with them, she had fallen on the ice. After the accident her father had had to rent a car in order to take her home. In the car, she had vomited a couple of times.

This dream and her parents' story released a flood of memories: her struggle to maintain seniority rights with her silblings, her pride at being taken on the trip while they were forced to remain at home, her chagrin and sense of defeat during the days in bed after the accident with her brother and sister playing around her. There were her hostile feelings toward her mother and her accusations that the latter had failed her, her triumph that the father had to rent a car for her.

Beside the affective revival of this childhood incident, the emotional situation surrounding the recent automobile accident was revealed. Her fiance had refused to accompany her to the party on the evening of the accident. Her sister, who was with her in

the car, had triumphed over her in attracting another boy, the driver of the car. The new accident had traumatically mobilized all the Oedipal tensions which were apparently solved at the time of the accident on the ice. The hate, fear and ambivalence of her earliest years returned. Because of her physically unstable state she had not been able to regain her old self-control and ego defenses without therapeutic help. After treatment which lasted 30 sessions, she recovered her cheerful pre-traumatic personality and resumed her normal activities.

Case 2

An officer who had been in analytic treatment with the writer for one and one-half years while still a student asked (five years later during the war) for a few appointments because many of his old fears had returned. He handled these fears rather well, but spontaneously connected them with unresolved memories from the time of the earlier analysis. He was a hyper-intellectual technical student whose first anxiety symptom appeared after he fell in love with a girl. His anxiety was crystallized around the concept of infinity; he feared that things had to be repeated *ad infinitum*. He dreamed about swimming in the ocean continuously—into eternity. The whole idea of eternal repetition made him ill.

His treatment followed the usual pattern. Infinity and eternity were the symbols of his mother-relationship. His central struggle in analysis centered about liberation from a strong mother-fixation. The new girlfriend aroused a conflict over his old loyalties. The treatment ended very satisfactorily.

As an officer, his new fears were precipitated by the following experience. He had been in a crash landing of a transport plane, suffering only subluxation of the right shoulder, which healed rapidly after treatment with a bandage. However, he lost his feeling of security; he worried about his wife (the girlfriend of the first analysis) and his child, who had been left behind in occupied territory. In his sleep, especially, he exerted great care to lie in a special position in order to protect his shoulder from being retraumatized. Often he awoke in great fear and had to turn to lie on his left shoulder. Through lack of sleep and accompanying anxiety, he felt a nervous wreck, although he hid his symptoms from his fellow-officers.

Under wartime circumstances, the writer could not see him often, but he was so ready to produce material that in the following five sessions he was sufficiently relieved to regard himself as well.

The first session carried us back to the close relationship with his mother, now dead. He recalled a threat his mother had often made—that if he did not stop his complaints to gain her attention he would become a girl. "Behave yourself like an angel or you will turn into a girl!" she admonished him. He still had the old picture of being an angel with wings, flying like a bird throughout eternity, and thus escaping the dread fate of being a girl.

The crash had traumatized his wings. Marriage and his mother's death had also "clipped his wings." This led him to further analysis of his old castration fear, a subject that had not played a key role in his former analysis. This short explanation of hidden old material, together with the revival of the old transference situation, cleared up his fears very suddenly. Later, when his path crossed the writer's occasionally, he reported himself free of fear.

The literature of war neurosis is full of examples of revivals of earlier traumatic experiences under the influence of stress and battle. Old patterns, well guarded, slumber under the surface of consciousness and though they may never have disturbed the patient's mental equilibrium, they are traumatized anew and begin a disintegrative process. Practically every traumatic neurosis is an activation of older traumatic experiences. That is why therapeutic analysis has to emphasize this old material—has to explore the charges which would not have been exploded if traumatic experiences had not destroyed the bulwarks of the ego.

III. The Preparation or Anticipation Neurosis*

The essence of the ego
is Anticipation of the future

—Fenichel.

The writer now wishes to describe preparatory—or anticipatory—mechanisms that occur less in actual analytic practice than in the psychotherapy of clear-cut psychosomatic cases.

*The principal concept presented in this section was first discussed in the *Geneeskundige Gids.*, The Hague, November 1935. (Ref. 3.)

The facts are fairly simple. In the preparation neurosis, conflicts and traumatic experiences are not so much facts from the past as they are an indication that future traumatic experiences and actions are anticipated. It is almost as if the organism prepares itself with a choice of neurotic defense mechanisms for decisions and actions which will in turn evoke new traumatic experiences. The neurotic wants to advance time, to borrow from the future. But contrary to the happy past, the future always implicates danger, the unknown, anxiety. The compulsive patient always postpones; he doesn't want to face a discipline, to face his own conscience.

The function of preparation and anticipation is a high mental function. Animals cannot bridge the space to the past and to the future. Man, instead, develops a system of manifold defenses against anticipated occurrences but may suffer at the same time from them. In patients subjected to prefrontal lobotomy, there is lack of anticipation. They show less anxiety because they do not mobilize mental forces. Observation of them indicates that the function of anticipation is highly related to the development of the frontal lobes in the brain.

Case 3

A young woman registers in an out-patient clinic which has only limited facilities for psychotherapy. She presents generalized complaints of fatigue and irritability. She has periods of anxiety and cries easily for no apparent reason. She also complains of palpitations, oppressive feelings in the abdomen and moments of sudden perspiration.

She tries to understand her feelings. There are no conflicts in her life. She is an intellectual with rather good capacity for self-observation. She is engaged, loves her fiance and shares a harmonious relationship with him. He resents only her illness. At first she refuses psychotherapy because she is "only physically ill."

Cathartic exploration reveals that the situation with the fiance is not so ideal as it was first represented, for she had given *his* opinion rather than her own. Actually, he is too good and too harmonious for her. He is so loving, so adoring, so happy with her that she hasn't the heart to interrupt or mar their relationship.

But sometimes she doubts, she feels inadequate. Deeply hidden somewhere is the thought that he is not the true love.

Her neurotic symptoms started rather acutely after she hesitantly took the initiative toward more intimate sexual relations. Her fiance refused on ethical grounds. After this rejection several confused feelings developed in the girl, besides the feeling of guilt, which overwhelmed her completely. Shame, guilt, catastrophe, fury—and the idea that she never would be satisfied sexually. Even ideas of suicide entered her mind, and these were followed by the fears and crying spells.

She tells her story, continually interjecting that "he is not to blame" and "he is so good—why should he be burdened with a neurotic wife?"

At the next session she relates a dream about her fiance. She saw him crying in a chair; she felt quiet and restful and awoke without fear and abdominal pains. After this disclosure the patient is silent for a long time, a new crying spell follows and then she hesitantly offers an explanation based on her own clarified insight:

More than a year ago she wanted to break the engagement, but she did not dare to do so because her parents would not have understood, and she did not wish to hurt her fiance. From time to time, she hinted about her doubts; but he looked so utterly unhappy that she did not want to burden her conscience with his sorrow. On the day following her direct sexual advances and his rejection, she knew, suddenly and surely, that she had to discontinue—but at the same time she thrust the idea aside. Now she understands her behavior. Her illness is already a partial retreat from him. She is preparing the final blow to his feeling of security about her. She identifies with him, suffers his aches and sorrows in anticipation. But it is also painful to her that the coming separation, which will be such a relief for her, will cause such pain to another. But now she has paid for her freedom and feels strong enough to take a definite step—after living through all the tortures and pains of the anticipation. *She had identified with her future victim in order to alleviate her own guilt.* After her final decision to break off the engagement, she was in a manic phase for a couple of days. She showed what every manic patient shows; she lived only in actual time, there was no longer any anticipation. She experienced the elation of only living in actual time.

Case 4

A married male homosexual enters treatment because of sudden attacks of asthma combined with crying spells. The anamnesis shows that in the past his wife—not he—has suffered from asthma. The wife knows about his homosexuality, their sexual relationship has been largely discontinued, but they are held together by mutually strong bonds of friendship. The wife never understood the deeper implications of his homosexuality, and he is still in continuous fear of being discovered by her.

In recent months, however, he had found a more permanent homosexual partner than usual; and both cherished the wish to live together. At this time the patient's inner disturbance begins. He has no strength to decide. He is afraid of hurting his wife, he reproaches himself for his homosexuality, and he reproaches himself for what separation will do to his wife. He identifies with her future conflicts and is vaguely conscious of what he is doing. He is mobilizing himself for the future battle. He knows that her asthma will reappear and that he will suffer from her discomfort. Nevertheless, his homosexual drive is sufficiently strong to draw him away despite his ethical impulses.

In the course of the analysis more complicated defense mechanisms come to the fore; the homosexual component is stronger than he believed. In this patient, too, the actual symptomatology before analysis symbolized an identification with his future victim in order to alleviate his guilt and pave the way for a future traumatic experience.

Case 5

A man is referred by a cardiologist because of a psychogenic heart attack. In the course of treatment he reveals that the attack helped him to stay away from his extramarital girlfriend and that he identified with the attack she would suffer when he broke up the relationship. At the same time the heart attack was a traumatization of the past and a revenge on his own mother, who died of heart disease when he was a boy of six.

IV. Timelessness and Precognition

A short note on this subject is needed because in every neurosis the need for timelessness and foreknowledge of future occurrence plays a role. We may explain this as the expression of the uncon-

scious wish for immortality and eternity. It is, at the same time, a reaction against reality because perception of time is confrontation with reality and its limitation. Infantile omnipotence defies time, defies schedules (Schilder[11]). Often when a patient announces his foreknowledge, his vision of the future, one can explain this vision as an illusion caused by these unconscious needs to put himself beyond time, evading the conflict of waiting, which means the conflict of separation.

However, there are also other processes involved in precognition. Often the analyst himself has a sudden foreknowledge of what the patient is going to act out in future days. It is as if the patient announces unconscious expressions of his future program and the analyst, through his understanding, is receptive to this unconscious transmission of personal foreknowledge.

Patients with suicidal fantasies are especially obsessed with the need for precognition. Such a patient asks himself, consciously or unconsciously, what may happen to him after his fatal act. He wonders about his revenge, about the eternal remorse which he may provoke in his "beloved." In his dire need, a flash of premonition may suddenly break through, as the writer observed in a patient, who for years struggled with a death-wish against his brother, and then, during a vacation in another part of the world "knew" it was going to happen, though there was no communication between them.[12]

The parapsychological literature is full of much more impressive examples of precognition. (See Tyrrell.[13]) One encounters in most of these cases precognition of future dangers for beloved persons.[14] Many well-controlled experiments have verified these phenomena which lack the usual physical and psychological frames of reference. For the writer's own part, in considering the phenomena which relate to unconscious foreknowledge, he is able to give an explanation, particularly for the unconscious anticipation-and-preparation patterns given in Part III of this study. If one person shares the other person's unconscious anticipations in a telepathic way—as so often occurs in the analytic process—one may also speak here of foreknowledge and precognition.[15] Unconscious personal foreknowledge is unconsciously signalled to the other person. In general, one may say that premonitions and precognitions are related to anticipation, telepathic transfer, a special

danger-mindedness, and a special ego-strain toward mastering the future with predetermined schemes.

Many of these phenomena can now be studied in an exact way with nearly unquestionable verification of facts. For the present purpose, it is enough to call attention to the phenomena, because of their relation to subjective conceptions of time. We accept the mystery of time more and more, convinced of its mystery by the modern physical approach and by the newer parapsychological evidence; we reject it at the same time because our infantile wish for omnipotence rejects the plurality of influences from outside, it pretends to live only in its own eternity.

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The ideas and case histories reported in this article contain many other points of psychological interest, but the writer wishes to limit his observation to the mechanisms of traumatic revival of the past and the anticipation of future trauma. The neurosis and its symptoms serve as a defense against past, present and future traumata. In its defenses, the organism steels itself against the traumata it has already suffered, and against the traumata and danger situations it may still experience. The ego is always in contact with past and future and contains both at any given moment. It struggles with the past, reactivates it again and again, and lays plans for the future, partially determining what will happen in time to come. Out of fear that things will *not* happen, they are anticipated again; they may become a repetitive anticipation. The repetition compulsion may here be seen as a resistance against duration, and the acceptance of fate. Things have to go according to a timetable, the patient has to know the data of the future, otherwise he cannot master the past (= the repressed drives).

The anticipation of affective consequences leads man to many kinds of passive defense, even to identification with his future victim to alleviate guilt. The psyche that does not dare to take acute risks pays by installment. Future sorrow is experienced in moderate doses and is thereby gradually denied. In the political sphere this passive anticipation may have very destructive results, as the present writer has shown in *Patterns of Panic*.[15]

The psychopathologist cannot afford to overlook this continual involvement of the time principle. While we investigate human beings now, their past is still present and can be revived; actual

occurrences can increase the severity of past traumatic experiences, and traces of future developments can be unraveled. In the neurosis, a portion of the patient's passive anticipation of future events stands revealed.

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FAMILY TAINT AND RESPONSE TO TREATMENT IN FUNCTIONAL DISORDER: A PRELIMINARY REPORT

BY HAROLD ZOLAN, M. D., AND NEWTON BIGELOW, M. D.

The purpose of this study is to evaluate, if possible, on the basis of reasonably objective material, the relationship between treatment response in patients with so-called functional psychoses and the absence or presence within their family constellations of mental illness. The intent is neither to prove nor disprove a thesis, but merely to present another small contribution which may eventually be fitted into the conglomeration of similarly-derived material to form a clearly-defined concept of the etiology of the "functional psychosis."

It will be necessary to define briefly several of the terms as they are used within the limits of this report. Included within the meaning of functional psychosis, are the manic-depressive and schizophrenic psychoses. The "family constellation" is a term to which some elasticity has been allowed, although the farthest removed relative considered was a first cousin. In this report the term "family constellation" includes parents, siblings, maternal and paternal grandparents, aunts, uncles and first cousins.

No therapeutic regimen had been used in either of the groups studied which differed in a quantitative or qualitative way from that ordinarily prescribed and carried out for the average state hospital patient. This included in all cases insulin shock or electric convulsive therapy, or a combination of the two where indicated; recreational activities; occupational therapy; hydrotherapy.

Two groups were studied. Group A consisted of 50 Marcy (New York) State Hospital patients of both sexes with diagnoses of functional psychosis, and with definite histories of mental illness in their family constellations as defined here. In the selection, cases were reviewed in chronological order of admission. The ill relatives were not restricted to those diagnosed as having functional psychoses. The chief reason for this was that it was impossible in some instances to determine a relative's diagnosis because he had not been hospitalized at Marcy. However, a relative-patient combination was not used unless there was, at the least, a definite history of hospitalization for mental illness for the relative concerned. Group B consisted of 50 unselected patients of

both sexes, diagnosed in the functional psychosis group and having no elicitable histories of mental illness in their families. They were admitted to Marcy during the same period as the patients in Group A.

The following factors were considered in evaluating the response to treatment: (1) age at onset; (2) diagnostic category as determined at the regular diagnostic conference; (3) length of illness prior to treatment; (4) type of treatment; (5) follow-up outside the hospital.

These data were compiled on patients of Groups A and B, and are presented herewith.

Results of Study

Since the patients were unselected from the standpoint of sex, there were 21 males and 29 females in Group A; 16 males and 34 females in Group B. In each group, coincidently, there were seven patients with the diagnosis of manic-depressive psychosis.

In those patients who left the hospital following treatment, extra-hospital adjustment was judged on the basis of social service contacts with patient and family, and on clinic physicians' reports on the patients' conditions during convalescent care. Adjustment was rated as "poor," "fair," "satisfactory," "good" or "excellent." These categories were delineated as follows:

(1) *Poor.* These were patients who remained actively psychotic, unable to support themselves, coming into conflict with their environments, and generally revealing themselves as lacking in social and economic adaptability.

(2) *Fair.* This group includes those who while lacking any outstanding degree of initiative or adaptability, were yet able to adjust sufficiently so that they caused no particular problems in their immediate environments. In most of these, adjustment fluctuated, and gainful employment was absent.

(3) *Satisfactory.* These patients were able to fit into their environments without too much strain, were gainfully employed at least part of the time, and although perhaps manifesting some emotional or mental abnormalities, were sufficiently well so that they were not an overwhelming burden to their families or society.

(4) *Good.* These patients were all gainfully employed if male, or, if female, were able to care for their homes and families in an adequate fashion. Here too there may have been some discernible

remnants of their former illnesses, or perhaps simply adjustments at somewhat lower levels than formerly.

(5) *Excellent.* These patients showed no particular evidence of previous illness, were responsible and even valuable members of society, and in all instances were adjusted in such a manner as to be considered recovered.

In Group A, 28 patients made satisfactory or better adjustments, as follows: satisfactory 13, good eight, and excellent seven. Of the other 22 patients in Group A, there were seven who were not well enough to leave the hospital, seven who made poor adjustments, and six who made fair adjustments. There was no information available on two of the patients. Of the group that was able to leave the hospital, five were subsequently either readmitted or returned from convalescent care. Three of these had made poor adjustments and were returned from convalescent care, while two had originally adjusted satisfactorily, but were later readmitted.

Of the 28 Group A patients who continued to show satisfactory or better recoveries, six were diagnosed as manic-depressives and 22 as cases of dementia præcox. Of the six manic-depressives, four received shock therapy. Of the 22 schizophrenics, 16 received shock therapy. Group A had a total of 31 patients who received shock. Therefore 20 out of 31, or 64 per cent, of the shock-treated Group A patients made satisfactory or better adjustments. Nineteen patients of this group did not receive shock therapy; and, of them, eight, or 42 per cent, attained satisfactory or better adjustments.

In Group B, 22 patients made satisfactory or better adjustments, as follows: satisfactory seven, good nine, excellent six. This group also contained seven who made poor adjustments, nine who made fair adjustments, and 10 who were not well enough to leave the hospital. There was no follow-up information available on two of the patients. In this group, there were also five patients who were returned, either from convalescent care or by readmission.

Of the 22 patients in Group B with satisfactory or better adjustments, three were diagnosed as manic-depressives and 19 as having dementia præcox. Two of the three manic-depressives and 18 of the 19 schizophrenics had shock therapy. Group B contained a total of 40 patients who received shock therapy. There-

fore 20 patients, or 50 per cent of those so treated in this group, showed satisfactory or better adjustments. Ten in Group B received no shock, and, of them, two, or 20 per cent, improved.

The patients in Group A who eventually left the hospital had been hospitalized for an average of 9.6 months, with a high of 38 months and a low of six weeks. The Group B patients who left the hospital had remained there for an average of 9.0 months, with a high of 31 and a low of three months.

The average duration of illness of patients in Group A, prior to hospitalization, was 31.2 months with a high of 15 years and a low of two weeks. The patients in Group B had been ill for an average of 44.1 months, with a high of 18 years and a low of three weeks. The duration of illness was calculated as that period prior to the hospitalization under consideration; and, in many instances, there had been one or more previous hospitalizations.

The average age at onset of patients in Group A was 30.6 years with a low of 15 and a high of 54. The average for Group B was 27.3 years with a high of 48 and a low of eight.

The improved patients in Group A had an average age at onset of 30.8 years, which approximates very closely the age at onset of the whole group. The improved patients in Group B had an average age at onset of 26.6 which also closely approximates the average of 27.3 for the group as a whole.

The accompanying table summarizes the findings.

Comparison of Results of Treatment in Patients with and without "Taint" in Family Constellations

	Group A ("tainted")	Group B ("Untainted")
Improvement in patients treated with shock.....	64%	50%
Improvement in patients without shock.....	42%	20%

Patients Making Adjustments Considered "Satisfactory" or better	Group A	Group B
Total number improved	28	22
Improved with shock	20	20
Improved without shock	8	2
Average age at onset of illness	30.6 yrs.	27.3 yrs.
Average duration of illness	31.2 mos.	44.1 mos.
Average length of hospital stay	9.6 mos.	9.0 mos.

Summary

Although the authors do not feel that this study is conclusive in any way, it is felt that the following salient features are of interest, particularly since some of them appear to vary from those that might have been expected.

1. The average age at onset of the "tainted" group was somewhat higher than that of the "untainted" group.

2. The response to treatment of patients in Group A, patients from "tainted" families, was better than that of the patients in Group B, in that there were 28 with satisfactory or better adjustments in the former group and only 22 showing similar improvement in the latter.

3. In Group A, six of seven manic-depressives improved, four with, and two without, shock. In Group B, three of seven manic-depressives improved, two of these with shock. Because of the small number of manic-depressive patients, it is probably not possible to derive any valid conclusion therefrom. Of 14 patients with this diagnosis in the entire series, seven received shock therapy.

4. In Group A taken as a whole, 64 per cent of the shock-treated patients and 42 per cent of those not treated with shock improved. This contrasts with Group B, in which 50 per cent of the shock-treated patients and 20 per cent of those not treated with shock improved.

5. Twenty of the 28 Group A patients who improved received shock, whereas 20 of the 22 improved patients in Group B received shock. This perhaps may point to a greater tendency to improve in "tainted" patients.

6. In Group B, there were three more patients who were not well enough to leave the hospital than there were in Group A.

7. Of the entire series studied (the combined groups), 50 per cent made satisfactory or better adjustments.

Marcy State Hospital
Marcy, N. Y.

SURVEY OF A MENTAL HYGIENE CLINIC—21 MONTHS OF OPERATION*

BY M. J. TISSENBAUM, M. D., AND H. M. HARTER, M. D.

It is intended, in this report, to present a survey, partly statistical, of the activities of a large mental hygiene clinic serving veterans with service-incurred psychiatric and neurologic disabilities, in the Borough of Brooklyn, New York City. Some limited and preliminary studies of this problem have already been made, notably those of Bonner and Maletz,[1] Adler and Burchard,[2] Hughes and McLaughlin,[3] and Adler et al.[4] However, it is felt that the present writers' experience is unique in that the nature and organization of their clinic differ greatly from most, and its problems are more diverse. Conclusions may be derived from their experience which could, perhaps, be of value to other clinics, as well as to clinics in the process of formation. Actually, mental hygiene care, on an out-patient level is, comparatively speaking, a new development, and this experience may offer something substantial in help or guidance.

The Mental Hygiene Clinic of the Brooklyn Regional Office of the United States Veterans Administration has resources available to it which are not available to most psychiatric out-patient clinics. The reasons are to be found in its great size, as well as in the heavy demands made upon it by the large number of veterans in Kings County (Brooklyn). One important resource is the clinic's location in a regional office in close liaison with other clinics covering the various specialties in medicine and surgery—a circumstance making for excellent "consultation" possibilities. Another resource of value is that this clinic treats neurologic as well as psychiatric disorders. Indeed the neurologic case load generally averages about 20 per cent of all patients carried in treatment, making available for all practical purposes, within the framework of the mental hygiene clinic, a neurologic section.

*Reviewed in the Veterans Administration and published with the approval of the chief medical director. The statements and conclusions published by the authors are the result of their own study and do not necessarily reflect the opinions or policy of the Veterans Administration.

Organization

The clinic is located on the third floor of a nine-story building, which serves as the Veterans Administration regional office. The mental hygiene clinic occupies most of its floor and is an integral part of the medical division of the regional office, which is the largest single unit in the building. The mental hygiene clinic is directed by a chief, with an assistant chief to aid with the various administrative responsibilities. The chief of the clinic is directly responsible to the chief medical officer, who in turn is responsible to the manager of the regional office for the proper functioning of the entire medical organization.

The clinic personnel consists of 20 physicians, most of whom are diplomates of the American Board of Psychiatry and Neurology, 17 psychologists, 18 social workers, two registered psychiatric nurses, two EEG technicians, and two attendants. There is, in addition, a clerical personnel of 40, to attend to secretarial and stenographic detail; and there are messengers. Affiliated with the clinic, there are, in addition, a number of residents in psychiatry from the College of Medicine of the State University Medical Center at New York (the Long Island College of Medicine), and a number of interns in psychology, as well as social service trainees. More will be said about them later. Of the 20 staff physicians, 12 are full time Veterans Administration employees and eight are on duty 20 hours a week.

The clinic is by no means an autonomous organization. It functions within the framework of the medical division and is one of the many clinics in this division. As a result, there is a constant interchange of ideas between this and the other clinics, by means of referrals, consultations, and mutual problems regarding veterans concerned. In this type of organization, it is clearly understood that psychiatry is a branch of medicine. For the veteran-patient to receive the best of care, it is necessary to have active co-operation between the various medical units as well as between the medical units and the rest of the regional office. Relations between the mental hygiene clinic and the other clinics have been maintained on a fairly high plane. Occasional differences have arisen which have always been cleared eventually by personal conferences between psychiatrists and other physicians concerned. Much misunderstanding and even some bias on the part of physi-

cians in the other clinics has been eliminated, and greater understanding and acceptance of psychiatry and its role in treatment has developed.

Treatment and Operation

It is basic that the major treatment resource would be psychotherapy. The psychotherapeutic approach used by the various personnel varies of necessity with the training, background and native ability of the physicians concerned. All members of the psychiatric personnel use psychoanalytic principles to a greater or lesser degree, depending upon their own individual background, training and experience; and various analytic schools of thought are represented. However, though analytic approaches of one kind or another may be used in therapy, it has not been considered feasible, advisable or practical to apply intensive analysis to the veterans coming for treatment. Some of the clinic psychiatrists are eclectic in approach and prefer to offer therapy at various levels, depending upon the patient-material with which they have to work. As Ziskind[5] has pointed out, remissions may occur with all the ideologies, therapeutic improvement can take place before the psychiatrist has completed insight therapy, and what are often considered to be basic problems frequently vary more with the psychiatrist than with the patient. The authors agree with Ziskind that concentration on maximal benefits with nonspecific therapies is justified and that emphasis on current stresses is very valuable. Rennie,[6] likewise, points out that the type of treatment employed will necessarily vary with the individual psychiatrist and his own orientation, and emphasizes the effectiveness of brief psychotherapy aimed at discussion of resentment, and ventilation, plus active social service help. Sandor Lorand[7] in 1938, speaking of clinic treatment, emphasized the inadvisability of delving into the deeper unconscious material in a clinic situation where interviews are limited and not on a daily basis. He felt that emphasis should be placed on the acute problems and the current emotional entanglements of the patient, and stresses the value of clinic therapy for patients with psychotic trends, for whom much can be done to keep them out of institutions. With this, the present writers are in complete accord.

In addition to the various modalities of psychotherapy, other methods of approach are available. The clinic uses electric convulsive therapy to a limited degree after careful consideration of

indications and counter-indications in the individual patients for whom such treatment is contemplated. The use of shock therapy in an out-patient clinic has been frowned upon to some extent, but it is the writers' opinion that it has definite value in a setting such as theirs. Hume[5] of the Langley Porter Clinic speaks of its effectiveness in about 100 cases of depressed, involutional and catatonic patients treated there by electric shock on an "ambulatory" basis. The use of electric convulsive therapy is determined by a "shock board," which reviews the case and interviews psychiatrist, patient and family concerned before a decision is made. Insulin subshock is also used extensively for many neurotics who have symptoms of tension accompanied by loss of weight—with some excellent results. It is obvious that deep insulin therapy cannot be used in an out-patient clinic. All such treatments, whether electric convulsive or insulin subshock, are naturally given with the understanding that psychotherapy must continue concomitantly.

Another therapeutic approach which has been greatly expanded recently is group therapy. It is hoped that effective techniques may be developed in group therapy so as to obtain satisfactory results for larger numbers of patients. Psychologists are active in this project, in which selected groups of patients are guided in group therapy by therapists specifically chosen for their capacity to handle certain types of patients. The entire program is under the control and guidance of the chief of the mental hygiene clinic, the chief psychologist and the consultant staff. This is in addition to the group therapy conducted by psychiatric personnel. Others have used group therapy similarly in an out-patient setting with satisfactory results, although probably not on the scale applied at this clinic (nearly 100 patients in group therapy currently). Kasanin[6] felt that it had outstanding effectiveness in his clinic, and Rennie[6] comments on its value in saving staff time, as well as on its therapeutic effectiveness.

Narcosynthesis is frequently resorted to, besides hypnosis to a limited degree.

It is policy for the psychiatrist to request consultations of a medical, surgical or other nature regarding a patient under his care, if such will help him in any way in the handling of a case. In this fashion, other pathology is sometimes discovered to be aggravating the basic psychiatric condition. Thus, an intercurrent condi-

tion suspected by the psychiatrist and verified by the consultant and which in itself prevents the psychiatrist from effectively treating the basic condition, can be placed under treatment on an adjunct basis until relieved, whereupon the psychiatrist can then more effectively help the veteran. This approach is permissible under Veterans Administration regulations and constitutes good practice.

Many neurologic conditions are likewise under treatment in this clinic and the most effective available therapeutic methods are applied. They include whatever may be available from a pharmacological as well as a physiotherapeutic point of view. It is a cardinal principle to recognize that neurologic conditions may have, and usually do have, superimposed upon them psychiatric "overlay," which in itself requires treatment.

Much has been said and written about the "team concept" in psychiatric treatment. There may be some value in describing the functioning of the so-called "team" in this Brooklyn clinic, after its rather extended period of trial. One great advantage is that the clinic has enough psychologists and social workers so that the personnel quota generally remains complete. A team consists of a psychiatrist, psychologist and social worker. It is recognized, as has often been stressed, that the personal relationship between therapist and patient must not be impaired by other personnel, since there would be serious interference with the transference situation in some instances. It is felt in this clinic that the psychologist and social worker can be called upon for considerable help in the handling of a new case. Later in the course of therapy it should be in the discretion of the psychiatrist as to whether either psychologist or social worker can be introduced safely into the situation. Wherever "transference" has not markedly crystallized, such use of ancillary personnel may be advisable or feasible. The "team" in this clinic generally functions as follows.

The psychiatrist carries those patients for whom such individual therapy as can only be given by the psychiatrist, is indicated. The social worker will carry those for whom case work involving situational and environmental factors must be undertaken and for whom individual psychiatric therapy is not especially indicated. The psychologist, in addition to testing, carries a limited number of patients in individual therapy under the guidance of his team psychiatrist. Because of the heavy load of patients, it has been neces-

sary to expand the role of the psychologist in individual therapy as well as in group therapy. Psychologists chosen to do therapy attend seminars directed by particularly well-qualified psychiatrists, wherein there is discussion of the various therapeutic problems which have arisen for the psychologist in his role as therapist. All patients assigned to psychologists have had previous "work-ups," both psychiatric and organic, by the physician-member of the team. In sum, the "team" consists of three professional persons who consult with one another formally and informally, regarding the problems they encounter with their patients. Some patients have frequent contact with all three members of the team, others, practically exclusively, with one member.

It must be pointed out, however, that the bulk of the patient-load is carried by the psychiatrist and that his province remains that of therapy. The bulk of the work done by the psychologist is that of testing for diagnostic and prognostic purposes, and that of the social worker is basically case work. The problem of the "roles" of the various professional people concerned with the patient in a mental hygiene clinic has been evaluated by others as well. Rennie[6, 10] stresses the fact that the psychiatrist is the key figure in his functions as diagnostician, psychotherapist and director of the many processes involved, with the psychologist to assist him, and the social worker often carrying the brunt of the time demands. The United States Public Health Service in its report on mental hygiene clinics[11] emphasizes that therapeutic activities by the non-psychiatric staff should be delegated by the psychiatrist at his discretion, and under his supervision and responsibility. This has been this clinic's policy and practice.

The writers' clinic has felt itself obligated to offer help or support, if not active therapy, to any veteran who applies for treatment and who is entitled to it by reason of a "service-connected" or "service-incurred" condition of a psychiatric or neurologic nature. Many other clinics are very selective in their choice of patients for treatment. Attempts are often made to determine feasibility for therapy at the time of application for aid. The result is that many patients either are unable to get help except by referral to other agencies, or are left to their own resources. It is the writer's candid opinion that all patients with psychiatric and/or neurologic disorders can be helped in one way or another, provided there are facilities available.

A clinic such as the writers' is obligated to offer any available help short of hospitalization. Only those veterans who require hospitalization fail to receive outpatient care; and they may receive it as a temporary measure pending arrangements for hospitalization. The entire concept is one of "supportive" out-patient care, with a fairly large number of patients on this "supportive" level. They are largely schizophrenics, rigid chronic neurotics, or patients with various chronic organic syndromes.

Little if anything can be done for them on a dynamic level, but they make some sort of social and economic adjustment, with the help of supervision on the part of family, social service, etc., and somehow benefit by the occasional visit paid to the therapist, at which time, more likely than not, there is often simply a "rehashing" of the same material that has come up, time and again in the past, at other sessions. Such patients seem to derive "support" from these visits where admittedly the therapy is superficial. Perhaps it is the knowledge they have of a clinic to come to, an appointment to be kept, and a doctor to consult, which serves as a "prop" or form of support. Ruggles[12] has stressed the fact that one of the great advantages of out-patient care is that the patient is able to remain at work and live at home, so that he has the security of a job and the help of his family, and can work his problems through, in his normal surroundings. With this the writers agree, with the added observation that the advantage is not for the patient alone, but for the community as well.

The frequency of treatment interviews is very largely dependent upon the type of patient, and to some degree on the case load carried by the individual therapist, who determines the frequency. Where a patient simply requires what is generally considered "supportive" care, he may be seen as infrequently as once or twice a month; others, such as epileptics and those with neurologic conditions of one kind or another, may be seen as infrequently as once every two or three months.

For psychotherapy, as distinguished from supportive treatment, interviews are weekly on the average, and where indicated and feasible, twice weekly. In rare instances a veteran may be seen three times a week. A factor relating to frequency of interviews is the availability of the clinic to the veteran. Many patients are employed and—to come to the clinic during the hours it functions—must take time from their work and receive permission from

their employers. Obviously, frequent interviews would be a hardship; and adjustments are generally reached between therapist and patient, so as not to make too many demands upon the veteran's time and job, and at the same time make it feasible to help him.

When patients are unable to come during the day, arrangements are completed with so-called contract clinics where they can be seen evenings. Approximately 500 such veterans are under treatment by two contract clinics. Most of these patients work, are unable to come to the clinic during the daytime at all, and so, have been "farmed out." The contract clinics are permitted to do "individual therapy" and some "group therapy" but none of the forms of shock therapy. All patients referred to such outside clinics for treatment receive complete "workups" before referral, including thorough physical examinations as well as psychological, social service and laboratory studies. Supervision of contract clinics is maintained by the regional office clinic; and on the whole, their service has been satisfactory.

There should be a final word on the "workup" given to a patient before therapy is assumed. The present writers are in accord with Ruggles[12] and Wright[13] on the necessity for a thorough examination, including physical and neurological studies, as well as a laboratory check on every patient. The psychiatrist who assumes the therapeutic role is expected to do a complete physical workup, including a neurological examination. The writers feel that this is as good a way as any for the psychiatrist to make his initial contact with his patient; and the procedure in itself has brought to light, in many instances, organic pathology which often is tied in rather closely with the patient's psychiatric illness. In addition, a preliminary physical examination, even though negative, has often helped to improve the attitude of the patient toward his therapist and has facilitated the job of the latter. The writers are referring to the many patients who come to them with negativistic attitudes toward psychiatrists, and who can't understand how they can be helped by just "talking." Some measure of confidence is frequently obtained when the patient realizes that his psychiatrist is a "doctor," who can handle a stethoscope and take a blood pressure.

Statistical Survey

Case Loads

The mental hygiene clinic was activated on November 17, 1947. On November 30, 1947 the census was 561. These patients included veterans transferred to the Brooklyn Regional Office Mental Hygiene Unit, because they were residents of Brooklyn and under treatment elsewhere pending the opening of the clinic, plus some new admissions between November 17-30. The 561 patients were:

	No.	Per cent
Psychiatric	430	76.6
Neurologic	131	23.4

Since that date there has been, in general, a progressive increase in patient-load so that on August 15, 1949, which completes the 21-month period of this survey, there was a grand total of 1,901 patients in active therapy at the clinic.

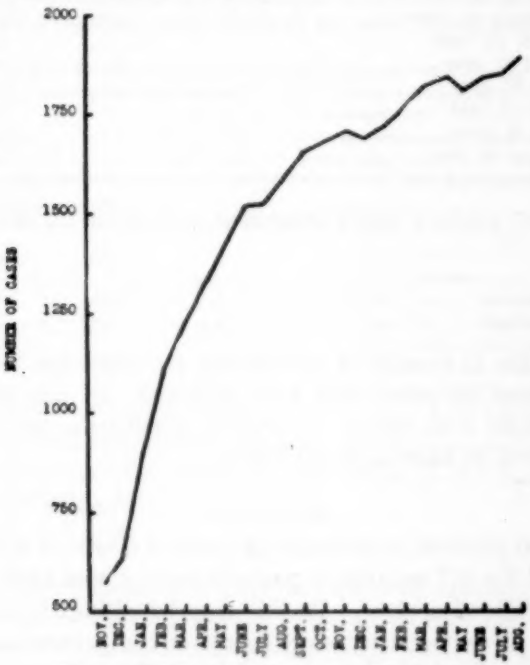

Fig. 1. Patient load, November 1947-August 1949

Table 1 presents figures at monthly intervals of the case-loads from November 1947 to August 1949, indicating the increase in patient-load. The trend is shown graphically in Figure 1.

Table 1. Case Loads at Monthly Intervals

November 30, 1947	561
December 31, 1947	645
January 31, 1948	904
February 29, 1948	1,129
March 31, 1948	1,247
April 30, 1948	1,321
May 31, 1948	1,389
June 30, 1948	1,519
July 31, 1948	1,522
August 31, 1948	1,586
September 30, 1948	1,660
October 31, 1948	1,687
November 30, 1948	1,709
December 31, 1948	1,687
January 31, 1949	1,722
February 28, 1949	1,751
March 31, 1949	1,822
April 30, 1949	1,849
May 31, 1949	1,815
June 30, 1949	1,841
July 31, 1949	1,853
August 15, 1949	1,901

The 1,901 patients under treatment on August 15, 1949 were:

	No.	Per cent
Psychiatric	1,514	79.6
Neurologic	387	20.4

During the 21 months of this survey, the clinic has had contact for treatment purposes with 4,617 veterans. Of this total, 3,800 were patients with purely psychiatric conditions, and 817 were considered to be neurologic problems.

Admissions

The 3,800 psychiatric patients represented a total of 4,606 admissions; and the 817 neurologic patients represented 1,049, a grand total of 5,655 admissions. To this may be added 28 patient-contacts who, after due study, were considered to present no disease, bringing the complete admission total to 5,683 patients.

The psychiatric admission total of 4,606 can be broken down further:

First admissions	3,127
Second admissions	1,102
Third admissions	333
Fourth admissions	44

The neurologic admission total of 1,049 can be broken down:

First admissions	626
Second admissions	312
Third admissions	90
Fourth admissions	16
Fifth admissions	5

Consultations

In addition, it is of interest to note the 201 consultations performed by the mental hygiene clinic for the other medical clinics of the Brooklyn Regional Office (Table 2). Of this total, 99 were purely psychiatric, 102 were neurologic; and it may be worth noting that the neurologic consultations exceeded the psychiatric.

Table 2. Consultations with Other Regional Office Clinics

Psychiatric:		Neurologic:	
Psychoneuroses	74	Peripheral nerve disease or trauma	43
No disease found	14	Herniated disc	20
Dementia præcox	7	Post-traumatic encephalopathy	15
Psychopathic personalities	4	Epilepsy	6
		Migraine	6
		Spinal cord tumor	2
		Buerger's disease	2
		C. N. S. lues	2
		One case each of cerebral thrombosis, multiple sclerosis, meningitis, brain tumor, neuroma and amyotrophic lateral sclerosis	6

The value of a mental hygiene clinic with neurologic facilities, as a consultative unit for other medical clinics in the same office is pointed up by this data.

Hospitalizations

Table 3 classifies the 243 hospitalizations of veterans after contact with this clinic. Of the 196 hospitalized for psychiatric reasons, 80 were "immediate hospitalizations," which is to say that they were hospitalized as promptly as possible after arrival at the

clinic and were actually considered as "emergent" or "very urgent" cases. The remaining 116 were hospitalized after they had been carried in treatment for varied periods, the average time being 93 days. Of the 47 neurologic patients hospitalized, 12 were "immediate" hospitalizations, and the remainder were hospitalized after an average of 166 days.

Table 3. Diagnoses of Hospitalized Clinic Patients

Psychiatric:		Neurologic:	
Psychoneurosis	96	Epilepsy	13
(The majority were diagnosed as mixed or acute anxieties, these constituting 79 patients)		Traumatic encephalopathy	11
Schizophrenia	89	Demyelinating disease	4
Manic-depressive psychosis	5	Dysfunction of peripheral nerves	3
Psychosis with psychopathic personality	3	Brain tumor	3
Involutional psychosis	2	Peripheral-vascular diseases	3
Paranoid condition	1	Post-encephalitic Parkinsonism	2
		Herniated disc	2
		Other varied conditions	6
Total	196	Total	47

Psychiatric Diagnoses

Table 4 presents a diagnostic breakdown of the total psychiatric patient-load carried in the clinic during the 21-month period of the survey.

Table 4. Diagnoses of All Psychiatric Cases in Clinic

			No.	Per cent
I.	Psychosis:			
	A. Schizophrenia		649	
		1. Unclassified	361	
		2. Paranoid	167	
		3. Simple	58	
		4. Hebephrenic	35	
		5. Catatonic	28	
	B. Paranoid condition		44	
	C. Manic-depressive (mostly depressed patients)		28	
	D. Involutional melancholia (all World War I veterans)		3	
	Total		724	19

II.	Psychoneurosis:		
	A. Anxiety reactions	1,225	
	B. Mixed neuroses	674	
	C. Somatization reactions	560	
	D. Conversion reactions	271	
	E. Obsessive, compulsive and phobic	121	
	F. Neurasthenias and hypochondriasis	68	
	G. Reactive depressions	57	
	Total	2,976	78.3
III.	Mental deficiency (including mental defectives with or without psychosis)	21	0.7
IV.	Psychopathic personalities (including what are commonly accepted as constitutional psychopathies, immaturity reactions, emotional instabilities, certain alcoholics, etc.)	79	2
	Grand total	3,800	100

It is conceded that the diagnostic classifications, shown in the breakdown in Table 4, are basically dependent upon the "service-connection" that each veteran carries. This is the condition which is considered to be "incurred in service," and such "service-connection" diagnosis has been reached after due and careful study by the Veterans Administration. It was to be expected that the "psychotic" diagnosis would comprise chiefly the so-called schizophrenic reactions, most of them "unclassified" in type and many of them fairly well established as predominantly paranoid. A study of the psychoneuroses indicates a preponderance of the so-called anxieties and mixed types, a result which is to be expected. It is interesting to note that there are a large number of somatizations as well as conversion reactions. There is probably some overlap in these two diagnostic categories which, perhaps, could be clarified by further study of the individual veterans concerned. The smallest psychoneurotic group consists of the reactive depressions, neurasthenias and psychasthenias.

It has been the experience of this clinic that many of the psychoneurotics present considerable schizoid coloring and it is the writers' opinion that many of these so-called psychoneurotics will ultimately turn out to be schizophrenics or could perhaps be classified as latent or borderline schizophrenics. There is much interest in this problem, with plans for further investigation into diagnostic criteria regarding such patients. Most such patients appear quite refractory to psychotherapy at their present stage. In addition, many of the so-called psychopathies present considerable schizoid

coloring; and, there again, the same problem of resistiveness to therapy presents itself to the therapist.

Neurologic Diagnoses

Table 5 covers the patients who received treatment for neurologic syndromes.

Table 5. Neurologic Diagnoses

Post-traumatic encephalopathies	329
Epilepsies	177
Migraine	88
Peripheral nerve syndromes (including nerve injuries, neuritis, neuroma, radiculitis, Guillain-Barré Syndrome, etc.)	75
Brain pathology (including brain tumors, C. N. S. lues, vascular incidents, etc.)	30
Post-encephalitic Parkinsonism	25
Multiple sclerosis	24
Other (including a variety of conditions such as Buerger's disease, spinal cord tumors and injuries, syringomyelia, Ménière's disease, amyotrophic lateral sclerosis, etc.)	69
Total	817

Duration of Treatment

Considering only those patients who have been under treatment for psychiatric conditions, the discharge rates and length of treatment prior to discharge are shown in Table 6.

Table 6. Discharge Rates for Psychiatric Patients

I.	Patients discharged after treatment of one month or less*	668
II.	Patients discharged after 1 to 3 months	425
III.	Patients discharged after 3 to 6 months	621
IV.	Patients discharged after 6 to 12 months	468
V.	Patients discharged after 1 to 2 years	103
VI.	Patients discharged after 2 years or more	1
	Total	2,286

A total of 2,286 patients were discharged during the 21-month period of the survey out of 3,800 accepted for psychiatric treatment. As a result there were, after August 15, 1949, still under

*These consist of three categories of patients: First, applicants for treatment who later refused to accept treatment for one reason or another; second, those voluntarily dropping out of treatment after less than one month; and, third those whose treatment was discontinued by the physician as being completely nonfeasible. The first two categories are by far the more numerous and to a great extent consist of veterans who were resistive to the idea of psychotherapy or who came to the clinic with some ulterior motivation, such as "pension problems."

treatment for psychiatric conditions, 1,514 veterans with psychiatric diagnoses.

A further breakdown of these discharged veterans described in Table 6 is pertinent from the point of view of diagnosis, using a division of psychoses, psychoneuroses, mental defectives and psychopathic personalities. (Tables 7, 8, 9 and 10.)

Table 7. Discharges of Psychotic Patients

I.	Patients discharged after 1 month or less	156
II.	Patients discharged after 1 to 3 months	103
III.	Patients discharged after 3 to 6 months	108
IV.	Patients discharged after 6 to 12 months	54
V.	Patients discharged after 1 to 2 years	9
V.	Patients discharged after 2 years or more	0
	Total	430

Of the 724 patients with diagnoses of psychosis, 430 have been discharged, leaving 294 veterans still under treatment after August 15, 1949.

Table 8. Discharges of Psychoneurotic Patients

I.	Patients discharged after 1 month or less	468
II.	Patients discharged after 1 to 3 months	307
III.	Patients discharged after 3 to 6 months	503
IV.	Patients discharged after 6 to 12 months	410
V.	Patients discharged after 1 to 2 years	94
VI.	Patients discharged after 2 years or more	1
	Total	1,783

Of the 2,976 psychoneurotics accepted for treatment during the period of this survey, 1,783 were discharged, leaving after August 15, 1949 a total of 1,193 patients.

Table 9. Discharges of Mentally Defective Patients

I.	Patients discharged after 1 month or less	8
II.	Patients discharged after 1 to 3 months	5
III.	Patients discharged after 3 to 6 months	3
IV.	Patients discharged after 6 to 12 months	1
	Total	17

Note that 17 of the total of 21 mental defectives carried in treatment during the survey were discharged, the majority of them in less than three months.

Table 10. Discharges of Patients Diagnosed as Psychopathic Personalities

I.	Patients discharged after 1 month or less	36
II.	Patients discharged after 1 to 3 months	10
III.	Patients discharged after 3 to 6 months	7
IV.	Patients discharged after 6 to 12 months	3
V.	Patients discharged after 1 to 2 years	0
VI.	Patients discharged after 2 years or more	0
	Total	56

The majority of the 79 patients with psychopathic personality diagnoses were discharged in six months or less, nearly half of them in less than one month. Most of them were "self-discharged." Obviously such patients are very resistive to therapy and in many instances appear at the clinic with ulterior motivations.

Table 11 presents the duration of treatment before discharge of neurologic patients.

Table 11. Discharges of Neurologic Patients

I.	Patients discharged after 1 month or less	33
II.	Patients discharged after 1 to 3 months	76
III.	Patients discharged after 3 to 6 months	103
IV.	Patients discharged after 6 to 12 months	116
V.	Patients discharged after 1 to 2 years	102
	Total	430

Of 817 patients under treatment for neurologic conditions during the period of survey, 430 have been discharged, leaving 387 veterans still in treatment after August 15, 1949.

The duration of treatment of various groups of patients can be shown in more graphic fashion in Figures 2, 3, 4, 5. In these studies it can be demonstrated that a very high proportion of psychotics leave treatment or are dropped from treatment in less than one month and that the great majority of them are under treatment for one to six months, the peak load being from three to six months. As for the psychoneurotics, the great majority are under treatment for from three to 12 months, although here again the peak load is from three to six months. However, as would be expected, far more neurotic patients are carried in therapy for extended periods (up to 12 months) than are psychotics. Neurologic patients, however, reach their peak load in the six to 12-

month group, and many have been carried for a period of one to two years. This is to be expected in view of the high proportion of chronic neurological cases seen in this clinic. The composite graph (Figure 6) presents these findings in relation with one another.

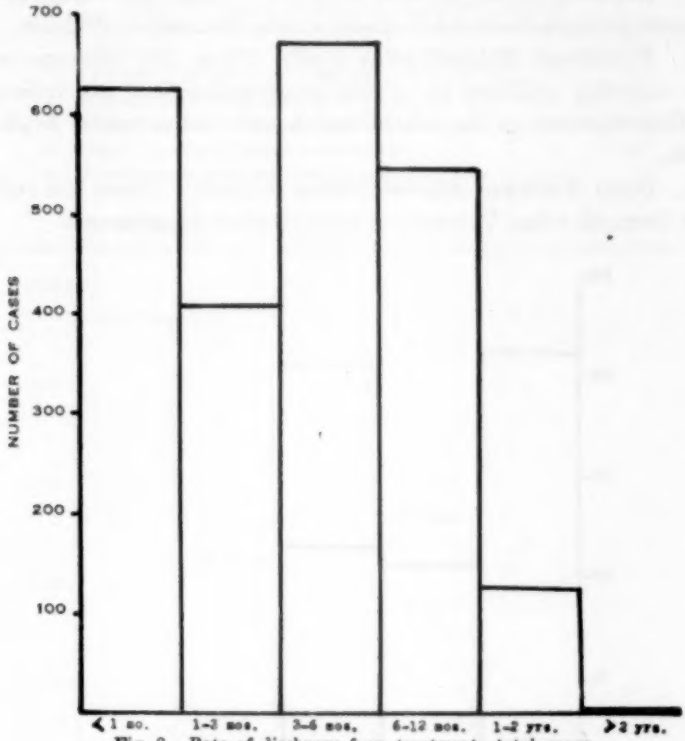

Fig. 2. Rate of discharge from treatment—total group

Referral of Clinic Patients

The sources of referral of veterans to the mental hygiene clinic for treatment can be divided into six categories.

1. *Self-Referral*: These are veterans who have come directly to the clinic through Veterans Administration channels either because of a desire for treatment or because they have problems which are more or less related to their symptoms. In the process of seeking help for these problems they are eventually directed to the mental hygiene clinic.

2. *Veterans Administration Hospitals*: Veterans discharged or on trial visit from Veterans Administration hospitals are frequently referred to the regional office mental hygiene clinic for follow-up care.

3. *Regional Office Medical Division*: These are referrals of veteran-patients from other clinics within the medical division.

4. *Vocational Rehabilitation Unit*: These are veterans who are receiving guidance as to jobs or education, and are referred by their contacts in the rehabilitation unit to the mental hygiene clinic.

5. *Other Veterans Administration Sources*: These are referrals from all other Veterans Administration departments.

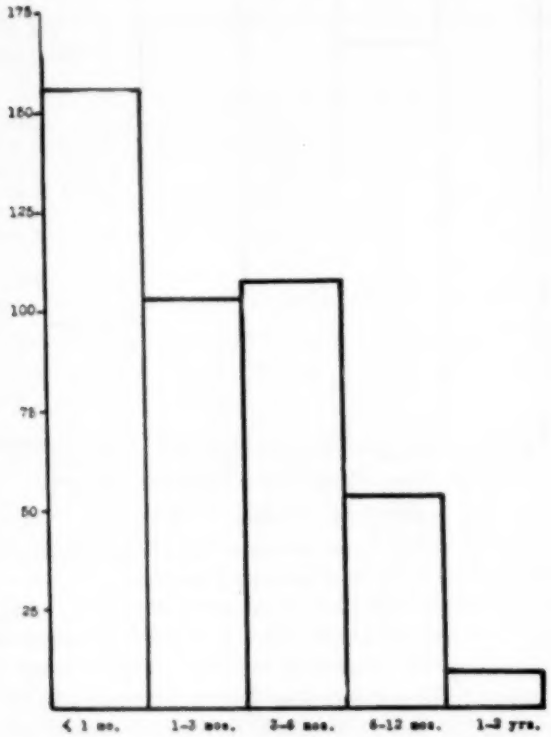

Fig. 3. Rate of discharge from treatment—psychotic group

6. *Non-Veterans Administration Sources*: Such referrals, generally speaking, come by way of service organizations.

Tables 12 and 13 present the sources of referral for psychiatric and neurologic patients, respectively.

Table 12. Source of Referral, Psychiatric Patients

1.	Self-referral	3,229
2.	Veterans Administration hospitals	37
3.	Regional Office Medical Division	270
4.	Vocational Rehabilitation Unit	135
5.	Other Veterans Administration sources	122
6.	Non-Veterans Administration sources	7
	Total	3,800

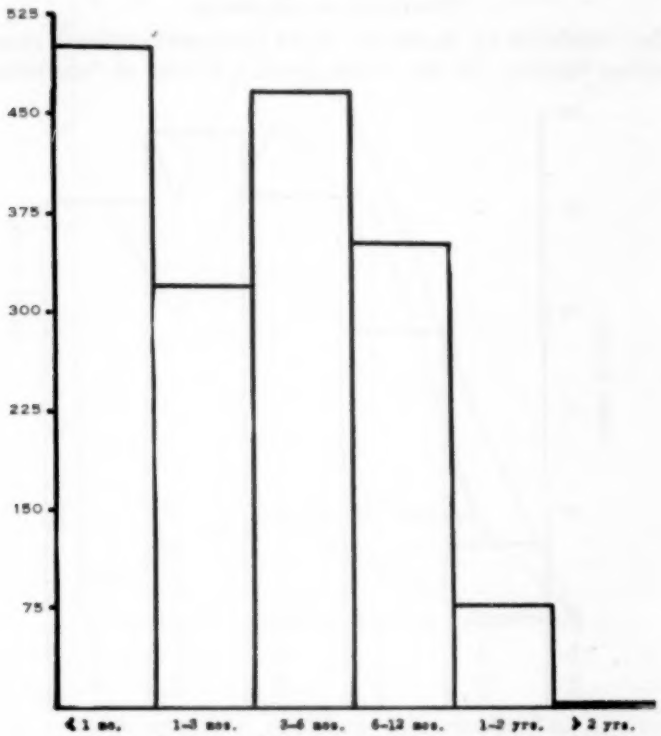

Fig. 4. Rate of discharge from treatment—neurotic group

As shown in the foregoing table, 85 per cent of these patients arrived at the clinic as self-referrals, in most instances seeking help directly because of their symptoms.

Table 13. Source of Referral, Neurologic Patients

1.	Self-referral	603
2.	Veterans Administration hospitals	11
3.	Regional Office Medical Division	87
4.	Vocational Rehabilitation Unit	66
5.	Other Veterans Administration sources	44
6.	Non-Veterans Administration sources	6
	Total	817

In Table 13, 73.8 per cent of the patients are self-referrals.

Condition on Discharge

The "*condition on discharge*" after treatment presents some interesting figures. In this study, precise figures of "condition on

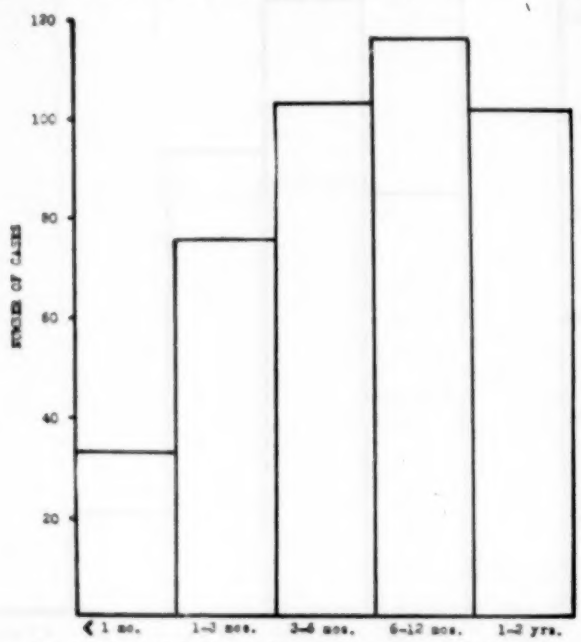

Fig. 5. Rate of discharge from treatment—neurologic group

discharge" in relation to diagnostic categories are not given. They will be incorporated in a subsequent paper, since their determination involves further careful detailed breakdown of records. However, a division has been made of veterans with psychiatric conditions and with neurologic conditions.

Of the 3,800 psychiatric patients accepted for treatment, 2,286 were discharged, leaving 1,514 still under treatment after August 15, 1949. Four categories of "condition on discharge" were made; these were: "much improved," "improved," "unchanged" and

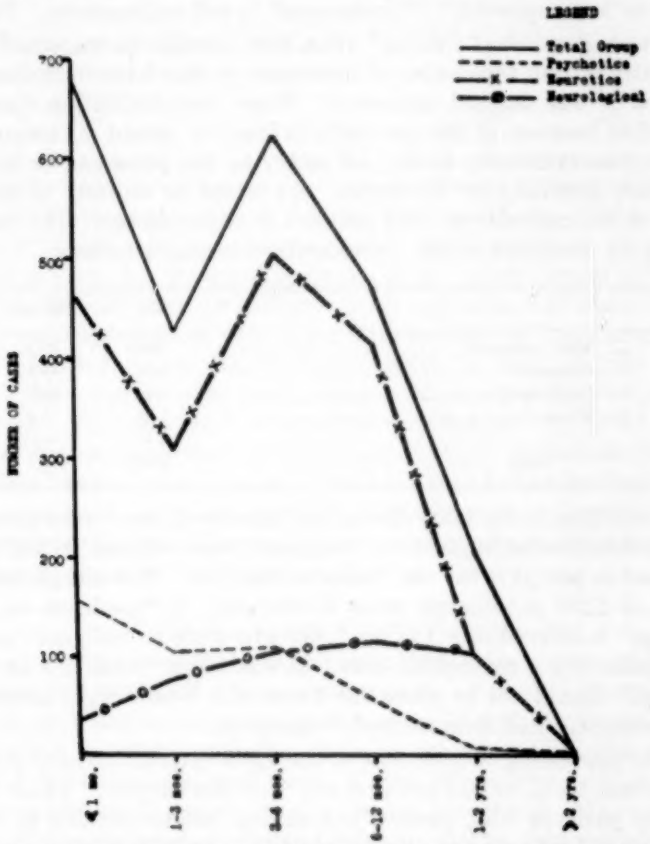

Fig. 6. Comparison of rates of discharge from treatment—total population, neurotic, psychotic and neurologic cases

"worse." To some degree the criteria used for consideration of "improvement" is based on definitions in a report by Ginsburg and Arrington.[4] A veteran was considered "much improved," if he was found to be practically symptom-free. (The term "recovered" was felt to be inadvisable.) If the veteran presented what was considered to be social or vocational improvement—wherein he was able to enter into social or work activities previously impossible, was better able to function in his environment, and in addition presented definitely better tolerance for his symptoms—he was held to be "improved." "Unchanged" is self-explanatory. Veterans were considered "worse" when their conditions worsened sufficiently during the course of treatment so that hospitalization resulted or was deemed necessary. Where hospitalization was not possible because of the patient's refusal to accept it, treatment often was eventually broken off either by the physician or by the patient, generally by the latter. As would be entirely to be expected, the majority of such patients were psychotics. The breakdown by condition of the psychiatric discharges follows:

	No.	Per cent
1. Much improved	409	22.2
2. Improved	899	48.8
3. Unchanged	442	24.0
4. Worse	89	5.0
Total	1,839	100

In addition to the 1,839 discharges described, there were another 447 veterans who applied for treatment, were offered it, but then refused to accept it for one reason or another. This completes the total of 2,286 psychiatric cases discharged. A "condition on discharge" is offered only for the 1,839 who were actually carried in treatment for a reasonable time. It was felt a "condition on discharge" should not be given for those who were simply screened for treatment and then refused to accept it.

It is interesting to note that of the 1,839 veterans discharged as described, 1,151, or 62.5 per cent are "self-dischargees." These constitute patients who, generally speaking, either decided to stop coming and informed the therapist of this, or just stopped coming without explanation. That would leave 688, or 37.5 per cent, who

were actually discharged by the therapist himself after the course of treatment.

Included in the total of those discharged, are 154 patients whose treatment was discontinued, usually early in the course of therapy, on determination that they were legally ineligible for treatment.

Of the 817 neurologic cases carried in treatment during the period of the survey, 430 were discharged after variable periods, leaving 387 still under treatment after August 15, 1949. The "condition on discharge" of these 430 follows:

	No.	Per cent
1. Much improved	49	11.4
2. Improved	266	61.8
3. Unchanged	93	21.6
4. Worse	22	5.2
Total	430	100

For neurological cases a veteran was considered "much improved" if his symptoms were greatly ameliorated or were no longer present for extended periods. Most "much improved" patients were epileptics, or sufferers from migraine, and some traumatic encephalopathies. Veterans were considered "improved" if they admitted to subjective improvement to some degree and where there was possibly some evidence of objective improvement as well. Veterans were considered "unchanged" if, after due course of treatment, there was no change in their conditions. Those labelled "worse" were generally patients who had to be hospitalized or were in such poor condition that they could not attend the out-patient clinic any longer. In general, these were patients with chronic progressive degenerative diseases.

World War I and Women Veterans

At this point it might be worth commenting upon some data regarding World War I veterans and female veterans. During the 21-month period of the survey there were a total of 128 World War I veterans in treatment in the clinic, 94 for psychiatric disorders, and 34 for neurologic conditions. These 128 veterans constituted 2.7 per cent of the total veterans under treatment. There were only 35 female veterans under treatment during this period. Of these 35, 27 were purely psychiatric cases, and eight were neuro-

logic. The figure of 35 female veterans represents 0.75 per cent of the total.

Neurology

In view of the fairly large proportion of patients with neurologic disorders applying for treatment, it has been felt advisable to set up a series of projects for both treatment and investigative purposes. Breakdowns of the different varieties of neurologic syndromes under treatment in this clinic and of general results of treatment have already been made. Brief comments on the various neurologic projects follow:

A. *The Epilepsy Project*

This includes all patients variously diagnosed as idiopathic and traumatic epilepsy in their various forms, as verified by clinical and EEG studies. The usual effective medications, either alone or in combination, have been made available to these veterans, these including phenobarbital, dilantin, tridione and mesantoin. It is the clinic policy to treat epileptics psychiatrically as well as by medication. Wherever the patient is amenable and co-operative he receives psychotherapy in addition to the manipulation of his medication.

B. *The Headache Project*

Wherever the symptom of headache is the main presenting complaint, the patient is assigned to the headache project, wherein there are three major categories of patients: (1) patients with migraine and migraine variants; (2) patients with traumatic encephalopathy; and (3) psychoneurotics, essentially regarded as patients with somatization reactions.

Patients with traumatic encephalopathies and migraines are carried as neurological patients statistically. All of them, in addition to receiving medication, have individual psychotherapy or group therapy. The usual drugs that are effective for headaches of different types are applied, including cafergone, DHE 45 and other newer medications which are presently being used on an investigative level. The headache project in this clinic is co-ordinated to some extent by our neurological consultant with the headache program at the Montefiore Hospital.

C. *The Multiple Sclerosis Project*

Multiple sclerosis patients at various levels of progression of their syndromes, have so far benefited more from group and individual psychotherapy than from any medication or physical approach. They receive the usual supportive measures such as liver and Vitamin B injections; but other drugs used to date have been ineffectual. The eight patients who have shown some recent improvement can no doubt be considered as having had spontaneous remissions, such as may be expected in multiple sclerotics.

D. *Parkinsonism Project*

This project is in process of development in view of an unexpected increase in the number of patients with a Parkinson syndrome.

E. *Post-Traumatic Project*

A post-traumatic project is being initiated because of the large numbers of post-traumatic cases. Investigation is now going on into the delayed effects of concussion experienced during war service.

* * *

It must be noted that all of the foregoing projects are approached not only from the point of view of neurology but also from the psychiatric angle, with recognition that all of these conditions are expected to have some psychiatric overlay. The importance of psychotherapy in neurologic cases cannot be sufficiently stressed. For instance, the morale factor obtained from group therapy for multiple sclerotics is undoubtedly of considerable importance to these patients. The re-education and guidance that epileptics receive in psychotherapy has been found here to have considerable practical value for them.

Education and Research

It is accepted policy, wherever feasible, to organize an educational program as one of the functions of a mental hygiene clinic. The Mental Hygiene Division of the United States Public Health Service, in a recent report,[11] emphasizes this point, and, in addition, states that a clinic should have an affiliation with a medical school wherever possible. Huston[16] has stressed "teaching" at his clinic as of considerable importance in elevating the standards of the clinic.

Since inception this clinic has served a role in the training of psychiatric residents and psychology interns. More recently, training of social service trainees has been initiated. With regard to psychiatric residents there is an affiliation with the resident training program of the College of Medicine of the State University Medical Center at New York (Long Island Medical College), sponsored by the Veterans Administration. These residents in psychiatry receive their initial year of training at a Veterans Administration hospital and subsequently spend a considerable amount of time at this clinic to obtain experience in out-patient psychiatry. There have been as many as 26 such residents registered in the clinic, each reporting for duty from once to four times a week. It is anticipated that this program will be a continuing one, in view of its obvious value to the Veterans Administration as well as to the trainee in psychiatry. In psychiatric training, the practice of psychiatry on an out-patient level is as close as one can come to "office practice." The Veterans Administration benefits by having additional personnel to carry patients in therapy and, in addition, a source of psychiatric personnel potentially available on completion of their training. It is interesting to note that seven former residents are now on the regular staff of this clinic, three of them as full-time physicians and four as part-time physicians.

Psychiatric residents do their work under supervision, this consisting essentially of seminars with their instructors. As far as possible, the types of patients assigned to residents vary with the known ability and experience of the resident; thus the more difficult patients are assigned to the more experienced residents.

It is generally felt that there should be a closer liaison between these residents and the regular clinic staff. Much of the instruction, supervision and guidance could come out of the clinic for the mutual benefit of staff and residents. Actually, at the present time, most of the supervision is given by instructors who themselves do not have any role in the clinic and, in most instances, no contact with the clinic at all.

The interns in psychology represent various schools and are closely integrated with the psychology section of the mental hygiene clinic. These interns are assigned to individual psychologists with whom they work rather closely and, as a result, receive close supervision of their work. There have been 11 or 12 such interns constantly in training.

At the present writing, there are no residents in neurology. This is considered a great lack in view of the considerable amount of neurologic material available. This clinic could offer an excellent opportunity for residents to receive experience in neurology on an out-patient level, and this would be rewarding to the Veterans Administration by making available a source of neurologists for its expanding hospital and clinic programs. A teaching consultant in neurology is available who could have a role in such a potential neurologic residents' program. At present, this consultant serves to give guidance to the various neurologic projects carried in this clinic, consults with the various physicians on specific neurologic problems, and directs a weekly seminar for the staff in connection with such problem cases. In these seminars, teaching in neuroanatomy and neuropathology is made available to the staff in correlation with the clinical material presented to the consultant. These seminars have been found extremely valuable, particularly to physicians preparing for certification by the American Board of Psychiatry and Neurology. The clinic now also has a consultant in electro-encephalography, with the aim of improving the quality of electro-encephalography in clinic use.

A teaching consultant in psychiatry attends the clinic on a weekly basis. The weekly psychiatric seminar for the staff is his major contribution. Thorough psychiatric preparation of patients presented for these seminars is a "must." These seminars are particularly valuable for the staff in that open and free discussion of psychiatric problems, philosophies and practice are thoroughly ventilated for the benefit of the entire staff.

In addition, the psychology section of the clinic has its consultants who, by teaching-seminars and consultations, keep the quality of work of the psychology staff at a high level.

Several research projects are constantly in progress in psychiatry, neurology and psychology; and there is a rather strong impression that such activities are necessary for the stimulation of staff personnel. Some of the projects now being carried through show promise of becoming contributions of real value to mental hygiene.

Summary and Conclusions

1. A survey of a large Veterans Administration mental hygiene clinic has been presented. It is believed by the authors that this clinic is organized, and functions, within the standards set by the

committee on psychiatric standards and policies of the American Psychiatric Association.[15]

2. Statistics have been presented which demonstrate the value of a mental hygiene clinic of this type to both the Veterans Administration and the community. In the statistical studies, have been recorded results and duration of treatment for both neurologic and psychiatric patients, sources of referral, consultation and hospitalization data, diagnostic breakdowns, patient-load changes, etc.

3. All forms and modalities of psychiatric approach have been demonstrated to be effective in such a clinic setting. However, there is need for more knowledge in the application of effective "short-term" psychotherapy. In addition, much can be said in favor of "supportive" interviews for so-called chronic patients who, in this fashion, are kept functioning more or less adequately without the need for institutionalization.

4. In this clinic, approximately 20 per cent of the case load is neurologic. With proper facilities and personnel, neurologic problems can be effectively handled in a mental hygiene clinic. There is added value in the clinic setting, in that adequate attention can be paid to concomitant psychiatric features, which are frequently present in the chronic neurologic patient.

5. A mental hygiene clinic, functioning in close liaison with other medical clinics representing the various medical specialties, has decided advantages for the patient because of available consultative services. There is added value for the psychiatrist, in that he does not lose contact with his colleagues in the other branches of medicine. While psychiatry needs close contact with the rest of medicine, non-psychiatric physicians also have much to gain by contact with psychiatry.

6. A better understanding of the relationship of psychiatrist to psychologist and social worker has resulted from practical experience. The role, in treatment, of psychologist and social worker in the "team" approach to the patient has been clarified.

7. An active educational and research program has been demonstrated to be a necessity to keep the quality of a clinic of this type at a high functional level. Of obvious value is the active participation of the staff in the training of psychiatric and neurologic residents or interns. Seminars and professional conferences are vital, and as many members of the staff as is feasible should participate in investigative projects.

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THE SELF-DEDICATION OF THE PSYCHONEUROTIC SUFFERER TO HOSTILE PROTEST AND REVENGE

BY IZETTE DE FOREST

That every neurotic patient presents the picture of self-defense is obvious. Neurosis is always a protective attempt, usually in childhood, to adjust to overpowering external forces; forces that demand the child's constant yielding, willing or unwilling, to the powerful figures in his environment; forces that impress upon the child specific principles of conduct, of thought, emotion and behavior; forces that do not sufficiently recognize or acknowledge the child's inherent goodness, his growth impulse, his very nature.

This early attempt at adjustment signifies that on one side of the parent-child struggle is the greater power, physical, intellectual and emotional, of the parents. On the other side, is the child's less powerful but innate and passionate insistence on growth, on self-expression. Each participant in the conflict has his characteristic strength. The parents' power lies in physical size, in age and in the capacity to offer the needed shelter and the loving milieu, which are essential to the child's existence and development. The child's power lies in his energy, an energy out of all proportion to the size of his body, and in his determination to grow according to his own inherited constitution.

That the conflict between parent and child should continue in our culture, which stresses intelligence, is a problem that not only psychologists but sociologists must solve. On the psychotherapists' shoulders lies the immediate burden of therapy for the resulting emotional ill-health. How can the child be assisted in preserving his integrity, his self-respect, his self-expression in the face of his parents' insistent and often differing principles of behavior and morality, and of the parents' overwhelming potency; how can he preserve his self-hood in the face of his need for the loving protection of these very parents? Or, if the child is of adult years, how can he regain his sense of self-determination, how can he visualize and free himself from his erstwhile parents, the often well-meaning but cruelly-blind figures of his innocent childhood? If he resurrects his actual infantile experience at the mercy of these powerful forces, how can he deal in the present with such an undigested experience? How can he dispel the ghost-like influ-

ence of the significant figures of the past, and again become the passionate entity which demands the opportunity to grow and develop in his own right?

The answer to these essential psychotherapeutic questions lies in the bringing into consciousness of the accurate memory, from the child's point of view, of the patient's struggle with his parents; in an acknowledgment that the need for loving care seduced him as a child, necessitating the rejection of his own demands of growth, the laying of them aside, and the succumbing to the demands of the environment; and in a re-evaluation, according to his contemporary standards, of the total childhood situation. The answer also lies in his recognition that his early self-betrayal resulted in the frustration of his inherent need to live lovingly, and resulted also in the repression, in the forgetting, of the fact that such a step was accompanied by an anger at giving way, and by a consequent unconscious dedication of his life to proving the dominating blindness or cruelty of his overpowering parents. "If you demand this of me, I must yield to you; but I hate you for it and will show you up!"

This angry protest or revenge lies buried deep beneath the childhood attempt to adjust with loving, or even slightly rebellious, reaction to the parents' insistent molding of his personality.

Few patients will at the outset of treatment admit their hatred of their parents. If they so do, the admission often represents a surface rebellion, which hides their early submission to those powerful forces. Yet in the lives of all neurotic patients, in their behavior toward others, they clearly show a vengeful spirit. This spirit underlies a paranoid suspicion of their fellow-men, a schizoid repression of emotions, a catatonic refusal of mobility, an obsessive emphasis on intellectuality; it underlies phobic and hysterical symptoms; it also underlies all varied maladjustments in interpersonal relations with contemporary society. Each such patient hides from himself and from others his unwitting dedication to a life of hostile revenge.

No other aim could accompany the yielding, the casting aside of, the patient's in-born harmless and loving nature, a nature that is born "trailing clouds of glory . . . From God, who is our Home."

The natural innocence of the infant needs and demands self-expression; an expression that proceeds from his particular nature, from his vast inheritance, an inheritance that differentiates

him from every other child. Because of this individual quality, he inevitably becomes in his parents' eyes a stranger; often unwanted, disliked or rejected. Here, a few months after birth, is presented a situation to which the baby is unaccustomed. The fetal period has provided acceptance and cherishing. The first months, following the difficult experience of birth, continue this promise. But with the development of the baby's idiosyncratic temperament, the cherishing gift is often gradually withdrawn. He is not recognized as a welcome addition to the family life; an enriching element, enriching in the very fact that he contributes new gifts and attitudes and ways of growth.

It is at this point in the child's life that his parents expose him to experiences of being molded and of consequent frustration, which belie his intrinsic value. In reaction, he must unconsciously decide upon the pursuit of his life's path. He must, if he is of strongly courageous nature, determine against all odds to assert his individuality, no matter what may be the external loss. In this case, and such cases are all too few, he remains comparatively healthy and becomes a contributory element in the evolutional history of mankind. Or he must begin to yield his essential nature and, in his development, fix his gaze upon the external powers which force their imitation upon him. He now loses his own likeness and accommodates himself to the likeness of others. Inherent in this latter unconscious decision, is the inhibition of his nature and the incipience of the motive of revenge. This results in psychosis or neurosis—in an unhealthy human being who, unless helped therapeutically, becomes a liability in the evolutional human program.

If this thesis is correct, revenge against the external dominating powers takes form in the early years of childhood and proves a determining factor in character development. The child's essential nature is seduced, is lulled to sleep, because of its unacceptable value to those in the infantile environment. A character pattern is developed, which proves acceptable to the formidable significant figures. Accompanying this new personality role, is an underlying anger at the frustration of the passionate growth impulse. The child's emphasis is displaced from his own nature, from within himself, to the external environment. This emphasis admits his failure to develop in his own right. He thus yields his integrity.

We now see in this acquired personality a deep falsity and, in

consequence, an unconscious anger at being forced into such falsehood. This anger is a self-assertive sign, for it is the only true and typical function which remains of his own nature. It at least announces: "I am still I. If I must die, I die fighting!"

Therapeutic assistance must face this total situation. It must allow in the patient conscious recognition of this hypocrisy and the resulting hostility. In what form does he reveal his falsity and its accompanying motive of revenge?

Each patient presents an entirely different picture from every other. His nature at birth was different from that of all other children; the figures in his intimate environment differed from all other parents. Each such set of circumstances must be viewed as individual. But always there has occurred in the childhood of neurotic patients an induced self-betrayal, an hypocrisy, resulting in hostile protest or revenge.

As examples of these unwholesome circumstances, the writer submits the following accounts of the early experience of three patients:

I

This patient, a pediatrician of 40 years of age, remembered hearing of an infantile experience of rejection. Breast-fed by his mother until 10 months old, he was suddenly deprived of this bliss. Another child was on the way; the mother, ill in the early months of the new pregnancy. The patient, in being refused his mother's breast, was given into the care of his grandmother. For unknown reasons he was neglected, starved and sickened.

At the age of four he distinctly remembers his father, a "heroic" and dominating character, who treated the mother as a slave. He remembers despising his mother, admiring his fascinating father. Soon the father proved to be cruel and threatening. Depending upon the father's unpredictable moods, the patient was praised or cruelly punished for the same act. He remembers being thrown angrily across the room for conduct which had previously won his father's admiration. Because of the mother's physical and emotional weakness he could find no consistent refuge with her. He could but submit to his father's power. He remembers yielding in terror to the behavior role which was impressed upon him. He was acknowledged as his father's heir, as a hero. He

must, as this hero, win in fights with his older brother. He must needs endure without outcry all punishment.

With growth, he became concentrated upon an illusion of self-grandeur and a despising of all women. He had little to do with men, always fearing them as competitors or as angry and threatening figures. Women were for him easy slaves who could be seduced, ill-treated and thrust aside. His reaction to both sexes resulted in extreme anxiety as to his sexual potency. This signified an acknowledgment to his father that he was still a child and no rival; and, to his mother, a despising of her womanly needs.

Here we see an angry revenge toward both parents: a refusal to be the heroic figure whom his father demanded; a punishment of his mother for her early rejection of his needs. Nowhere could be seen his essential nature. His life-attitude toward all human beings was one of vengeance.

Who was he at birth? What was his innate temperament? Suffering at an early age from the mother's negligence and from the father's cruel domination, his own gifts and capacities were thrust aside into unconscious depths, his life impulse was given over to an existence of impotent revenge. His parents were responsible for the loss of his self-hood; they would, in his life-long fantasy, see what they had created, an automaton devoted to a life which they controlled.

"I hate you! I hate you! I hate this whole mess! Can't you see what you've done to me? Well, I'll show you! I'll *be* what you've made me and that will serve you right! Then you'll be ashamed of yourselves!" was the unconscious outcry of this suffering human being.

II

Another patient, 35 years of age, a priest of the Roman Catholic church, had also unwittingly given over his fate into the hands of his parents.

The youngest of four children, he remained for many years the blond and curly-haired favorite of his mother. She seduced him, by her physical attentions and by her anxious protectiveness, to assume a passive role. He was not allowed the companionship of his older brother, which would have led him into boyish dangers; nor that of his father, which would have taught him to become an active farmer's son. His only childhood companion was his

mother, a fanatical churchwoman, a believer in original sin, and a woman fearful of worldly ways. Her baby was from birth dedicated by her to the church.

He remembers his longing to play with the boys of his own age, his wish to take part in farm activities, his resentment at religious rituals, both at home and at church. He remembers also his pleasure in his mother's constant attentiveness, her bribery and corruption. She bathed him until his twelfth year. Often he slept in her bed. His adolescent fantasy took this form: If his mother would pursue her physical care of him in recognition of his growing sexual impulses, she would then teach him to attain his manhood. Then he could take his rightful place with his brother and father, both of whom had always neglected him and despised him as a "sissy." It was in these teen years that his mother, sensing his sexual demands, reproved and rejected him. This meant for him the frustration, the denial, of his manhood and the final loss of brother and of both parents. He belonged to no one. The outside world could have no use for this untutored boy. The members of his family despised him.

In dismay he turned to the only source of security, the church. Here he could redeem himself in his mother's eyes and could take an esteemed place with his brother and father, both of whom were active Catholics. He could indeed attain a superiority to these men of the family, to most men, by becoming a famous preacher. This would prove his worth and give him in his superior eminence, the opportunity simultaneously to revenge himself upon his mother for her rejection, upon his father and brother for their neglect and for their refusal to rescue him from his mother.

To become a priest was an easy goal, for he possessed an excellent mind, an appealing presence and an interest in social betterment. He won a certain success, which, however, was increasingly undermined by a spirit of hateful vengeance. This took form in his delight at accusing his parishioners of their evil doings. Increasingly aware of the danger of this compulsion, he sought therapeutic aid. He could not understand his constant temptation to preach angry sermons; his despising attitude toward the women of his congregation; and, during the church services, his frequent hysterical symptoms of compulsive blushing, dizziness and liability to fainting spells.

Under therapy he discovered that his role as priest functioned as a self-bribe, with its financially-secure and easy life, with the beauty of the church ritual, with the opportunity for fame. It assured him a respected position among the men and women of the community. It also protected him, in his asceticism, from his sexual impulses, originally disapproved of by his mother in his adolescent years. But above all, his priestly role allowed him the expression of self-righteous anger and hostility, disguised as "hunger and thirst after righteousness." This early passionate need to revenge himself on his childhood family threatened increasingly to pour itself out in hatred upon his congregation and, in so doing, to undo his dedication to the church and to bring about the destruction of his sanity.

III

A third patient, an accountant by profession, 40 years old, complained in his first interview that he could keep no job for more than a few years. In each position he began at the bottom, learning the business from the beginning. He then easily reached a position of importance and responsibility. Anxiety then overcame him; he found it impossible to delegate responsibility; he felt himself compelled to attend to each simple duty; he found no day long enough for the carrying out of this compulsion; he began to procrastinate, to overlook essential tasks; he began to fear the displeasure of his superiors; he forced himself to resign his position; he, however, left the company with excellent references and to the regret of his co-workers. This cycle repeated itself ad infinitum. He finally became convinced of a powerful unconscious determinant and of his need for psychotherapeutic help.

He had been trained from his earliest years to "please others"; to forget himself, to be as others wished, but especially "to please." Although of native intelligence and curiosity, his capacity for interests remained undifferentiated; he could not specify any particular concern. "I am interested in everything. I've never known anything that did not interest me." His curiosity, however, remained entirely unsatisfied. His only wish expressed itself as a determination to use his keen sensitivity to learn what others wished of him; and to succeed in assuming all responsibilities that might be thrust upon him.

The physical symptom of duodenal ulcers gave hint of a childhood oral frustration. This hint was eventually substantiated when he spoke of the extreme poverty of his early years, of the large number of step-siblings brought into the family setting by his father and his step-father. Another important substantiation lay in the story of his father's death, when the patient was a child of five. He remembers the scene with his sorrowing mother and grown step-brothers around the death-bed. His mother was then eight months pregnant. He remembers the solemn words of his dying father: "Now, son, you will be the man of the family. You must now care for and support your mother!" "And I always have," continued the patient. "From the time when I was eight years old and a caddy at the nearby golf links, I have given my mother one-third of what I earned. One-third went to her for my board, one-third to her for herself, and I kept the other third."

He remembers no emotional reaction to his father's death; no sorrow, no pity for his mother or for himself, no anxiety, no rebellion at the unsuitable and unfair behest of his father. He loved both parents and was kindly treated by them. He was happy at his mother's second marriage two years later. He loved his step-father and the two new step-brothers, who, again, were much older than himself. Caught between two sets of grown step-siblings, who were devotedly cared for by his mother and were able, but unwilling, to assist in her support, this child assumed without conscious resentment the partial support of his mother and himself. He was her one and only son. To care for her was his duty, as impressed upon him by his father.

That he accepted this duty with conscious willingness, seemed to be due to his devotion to his parents, to the entire family; to the insistent training to please others; and to the emotional fact that at the age of five he was prematurely regarded as a grown man. Deprived of the recognition of his childhood needs for dependence and support (food and shelter), he was forced to repress these yearnings and to replace them with a totally false outlook on life. In one moment he gave up his position as a child and became a substitute father. The adults of his family, especially his mother, became for him his children. No wonder that the digestive tract of this child, starving for the emotional nourishment of childhood, developed additional mouths by way of ulcers.

He remembers only one occasion of resentment in all his boyhood. When the youngest caddy on the links, he resented the long hours of waiting for a client and the dirty stories and words used by the older boys. These latter he forced himself to use in order to please his companions. He also trained himself to eliminate these words from his vocabulary when at home, in order not to displease his "parents."

It seems impossible that such a childhood environment would not have created a conscious rebellion in this patient. That such rebellion was thrust into the unconscious realm was undoubtedly due to his sensitive affection for his kindly "parents" and to their insistence on the expression of his loving-kindness to others, a loving-kindness which was in keeping with his essential nature.

It was, however, inevitable that the life-long distortion of this natural gift at the hands of others, but with his own connivance, should initiate unconscious hostility. He could not be consciously angry and vengeful and at the same time be "pleasing." The revenge must therefore assert itself in neurosis. This assertion took form whenever the patient in his later years had proved his capacity for responsibility. At this point he would begin his program of self-sabotage. He felt himself failing in his responsibilities. He feared the consequent displeasure of others. He forced himself to resign his job but kept the respect and goodwill of those in superior positions. Again, however, he must start at the bottom of the ladder as if a little boy of five years of age. In this symbolic way he cried out for succor and support. He unconsciously called attention to the fact that he was too young to be held responsible for the support of others; that if they insisted on his being grown up, he would show them that they asked too much of him; he would fail them and himself; he would, after raising their hopes, dash them again. His neurosis was thus not only a cry from his heart that he was a starving child in need of nourishment; but was also an attempt to punish all adults, all those in any way superior to him, for not recognizing his need and fulfilling it; and for their unfair and overwhelming demands upon him.

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Each neurotic sufferer has developed his particular form of neurosis as a hostile expression of protest and revenge against the overpowering figures of his early years. The parents' power need

not be cruelly used. Indeed, it is more often well-intentioned, and even kindly, as in the case of the third patient. It must, however, have been forceful and dominating. It must have left no doubt in the child's mind as to the existence of authority in the parental figures. This predicates submission on the child's part. If rebellion is partly conscious, it must be immediately repressed because of the child's need for a cherishing milieu. This need is corruptible, easily seduced and falsified. A whole system of distorted and false values is then initiated by the hungry child at the hands of those who are physically and emotionally in power.

The dynamics of neurosis can be freed from such distortion and be healthily reintegrated only by the dynamics of therapy. The poison of hateful vengeance can be distilled away only by the therapy of love. Therefore, the essential element in psychotherapy consists in rendering useless the unconscious attempt of the patient to revenge himself on the overpowering ghosts of the past. Although these attempts have always proved impotent, never having brought the significant figures or their surrogates to their knees, they have continued compulsively, with the hope of eventual success. This hope must, with the therapist's aid, be proved unfounded. It must be exchanged for a new set of value standards. This exchange can only occur with the realization that there is in the cherishing therapeutic situation no question of authority, of domination, whether kind or cruel. There is no impingement of standards or values of one co-worker upon the other. There must be, on the other hand, a mutuality of respect and regard, a sharing of responsibilities.

As the neurotic patient yields, in therapy, his useless resentment and revenge against the forceful and destructive figures of the past, he faces a healthy present which requires no submission and a future in which he will retrieve and develop the buried constructive elements of his nature.

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SPONTANEOUS REMISSION OF SCHIZOPHRENIC PSYCHOSES FOLLOWING MATERNAL DEATH

Report of Three Cases

BY MAX COHEN, M. D., AND LOUIS M. LIPTON, M. D.

The remission of acute schizophrenic psychosis shortly after maternal death is not an unusual or "freak" occurrence. It is a familiar phenomenon to clinical observers in mental institutions, and to nurses and attendants who have worked with schizophrenic patients over periods of years. However, a search of the literature by the present writers failed to reveal any reports on the subject.

This study was initiated by the coincidental occurrence of this phenomenon in two male patients within a period of a few months on the insulin service of Brooklyn (New York) State Hospital. Both patients showed striking remissions of psychotic behavior within a short time after they were informed of the deaths of their mothers. A third case reported here was observed more than a year before this study was started, but is included because it illustrates the same phenomenon in a female patient.

Case 1

R. L., a 22-year-old Jewish youth, was admitted to Brooklyn State Hospital from the Kings County Hospital observation ward on February 19, 1949. Anamnestic data obtained from the patient's father and brother were considered reliable.

The patient was an "unwanted but accepted child," eight years younger than his only brother. During infancy he cried a great deal and was "a very poor eater," but in other respects his behavior, development and training were not unusual. The family lived in a small town in Connecticut in which there were no other Jewish residents, and this is said to have limited the family's social relationships in the community. When the patient was two years old his mother went into business, and his care was left to a "very close maid who regarded the child as her own."

The father and mother always quarreled a great deal; he was described as an active masculine person and she as a domineering, aggressive, overprotective person. When the patient was five, his parents were divorced, and he very rapidly became estranged

from his father. He was always treated like a baby and was overprotected by his mother and the maid.

As a student in elementary school and high school, R. L. did well, and was encouraged in his studies, but his sexual education and curiosity were always suppressed by his mother. He was not a friendly boy, although he had a few casual friends. He showed little interest in the opposite sex. At the age of 15 he suffered a head injury with concussion, but recovery was uneventful. He entered the army at 18 and received an honorable discharge two years later.

On returning from the army he was observed to be "very shut in and quiet"; but after occasional trips with his mother he would become overactive and extremely self-assertive. He attended three art schools in quick succession, but was unable to adjust in any of them "despite some talent" because he seemed unable to accept criticism from his teachers. Although he seemingly received generous treatment from his teachers, he did poorly and he felt mistreated.

Early in 1949 he was informed that his mother had cancer, for which she was hospitalized. On February 11 he became very disturbed, walked around a swimming pool for three hours "waiting for cancer to come down in human form," and "orated" in the student lounge of his school about the atomic bomb.

R. L. was taken to Kings County Hospital where he was restless, agitated and suspicious. His manner was pompous and philosophical, and he answered questions irrelevantly with such statements as: "Anything creative is good. Man is made creative and not destructive. I never trusted anybody except my mother. She trusted people and ruined her life. He better find that cure for cancer. I'll find out a cure because I won't rest until it is found. It is eating up my mother."

At Brooklyn State Hospital, the patient was condescending and arrogant. He assumed studied stances and postures to show his body in its most engaging and dramatic aspect, continuously fingering his arms, chest and back, as if admiring them. He assumed an air of superiority toward everyone who spoke to him, and, in his productions, betrayed a definite persecutory and grandiose trend. "I told the nurse at school not to try to be a man. A colored man was the first to hint that Adolf Hitler was in the bed next to me.

I got a hunch that Hitler is in this hospital. I am sure of it." Hallucinations were denied and his sensorium was clear.

His overactivity, rambling and paranoid attitude continued; and he appeared to be going into a state of exhaustion. He received a course of combined insulin and metrazol shock therapy and showed some improvement in behavior. But, though quieter and more co-operative, he still behaved in a superior manner, and spoke irrelevantly about "fighting to make this a man's world because it shows art as my life's work." While in insulin coma he would frequently scream out for his mother and would ramble unintelligibly about her. He attended group therapy sessions where he freely expressed hostility toward the other patients and the hospital staff. He exhibited extreme self-confidence and an exaggerated impression of his abilities to the point of actual grandiosity; he continued to speak of prejudices against him at art school because "the instructors were jealous" of his talents. At this time he refused to recognize the gravity of his mother's illness and accused the hospital of detaining him unjustly.

On April 20, the patient was told that his mother had died, and he accepted the information without any marked reaction. Within a few days, however, he showed a striking change in behavior and attitude. He dropped his façade of superiority and hostility, and he became friendly and co-operative on the ward. In the group sessions, he spoke more logically and coherently. He accepted the fact that he had been ill, and he attributed his illness to the simultaneous occurrence of his mother's illness and his difficulties at school.

He was placed on convalescent status in the custody of a cousin on June 7, 1949, and has made a good adjustment up to the time of this writing. At present he is living in Boston and attending art school. Reports indicate that he is doing well.

Case 2

M. W. was admitted to Brooklyn State Hospital on March 31, 1949 from the Kings County Hospital observation ward. The anamnesis was provided by his father and was rather vague and scanty in details.

The patient was 21 years old and had lived in Brooklyn all his life. Both parents were foreign-born. The father described himself as "emotional, sensitive and idealistic, similar to the patient in personality." The mother was described as "high-strung, worri-

some and devoted to her home and family." The patient was the sixth of seven siblings ranging in age from 17 to 35, and all except the patient were said to be well-adjusted.

In make-up the patient was described as "always good-natured, pleasant and anxious to please. He was shy and retiring, and hesitant about asking for anything even when he was entitled to it." In the army he was "too modest to undress in front of other men, and he was always easily hurt, especially when others failed to live up to his high ideals."

In spite of his shyness, he had a few casual friends, and a girl-friend in whom he was very much interested. His record at school was fair, but at 16 he left because he wanted to work. He worked as a clerk in a fruit store until he was drafted, in April 1946, into the army, where he served until honorably discharged 18 months later. Since that time he had had no regular employment. One job was "too hard," another "uncongenial," and, in another, he was "abused."

After discharge from the army he "seemed nervous." For several months prior to hospitalization his habits were reported to have been irregular. He stayed out late and often slept all day. He refused to eat, talked a great deal, and then complained about hearing voices and noises. For a week before hospitalization he refused to allow his parents out of his sight and followed them everywhere.

At Brooklyn State Hospital, M. W. was actively disturbed and required restraint. He mumbled irrelevantly about people chasing him and "voices upstairs." He appeared confused, and he was only vaguely oriented as to place and time.

The patient was transferred to the insulin service on April 6, 1949 where he paced up and down the hall hallucinating, and screaming, "I want my Jewish mother and father." A full course of insulin coma, combined first with metrazol and later with electric shock, was administered; and, except for a brief period in May when he improved by becoming quieter and more manageable, his course was characterized primarily by progressive preoccupation, withdrawal, and emotional deterioration. He hallucinated continuously and mumbled that he heard his mother's voice upstairs. He pleaded to the nurses to let him visit her. His emotional reaction was alternately apprehensive and silly. At times he would scream out such statements as: "I don't want to kill my parents.

I don't want my Irish parents." His contact was poor, and he frequently behaved in a silly and childish manner. On two occasions he impulsively struck other patients with a chair, after which he expressed remorse and blamed the occurrence on his hallucinations. He talked continuously about his parents, and especially about his mother, who did not visit him because she was ill.

Late in July the patient's mother died; and when he was informed on August 2, he showed a marked emotional reaction. He covered his face with his hands while he cried and sobbed bitterly. He declared that it was his fault, that he had killed her, that he did not deserve to live. Within 24 hours he had returned to his previous state of apathy and preoccupation. His condition remained unchanged for a week, and on August 8 he was transferred to a continuous treatment service for further care.

Two weeks later the writers were amazed to find that he had improved tremendously. He was no longer hallucinated; he was in good contact; and he showed fair emotional tone. On the ward he was co-operative and friendly, and, when asked about his previous hallucinations and delusions, said, "I did hear voices. I can't understand where they came from. At times I could hear a noise and would feel that some person would pass me by. I then turned and saw this person pass. This made me feel that I was psychic. It was all my imagination. I still sometimes turn around to make sure that people are talking because I am afraid that I might still be hearing imaginary voices, but I don't seem to be." His productions were relevant and he expressed a desire to go home. He was at a loss to account for the disappearance of his symptoms. He said he was glad that he was well again and was reluctant to talk about the subject.

The patient was placed on convalescent status on September 6, 1949 and has been followed in the convalescent clinic. He now works in his brother's store and seems to be making a good adjustment. When last seen on November 2, he was asked how he felt about his mother's death and how that might have contributed to his improvement. He was unable to see any connection.

Case 3

V. C., a 28-year-old woman, was admitted to Brooklyn State Hospital on November 6, 1947. Her anamnesis was obtained from her husband who was considered a reliable informant.

The patient's father had been hospitalized on the Kings County Hospital observation ward, but apparently was never committed to a state institution. The family history was otherwise negative for nervous and mental diseases.

The patient was born in Brooklyn, the older of two sisters. Little information was available pertaining to her early life; but she was graduated from grade school and left high school after one year to go to work as a salesgirl. She married five years before this hospital admission after a three-year courtship, and, at the time of admission, had an eight-month-old son.

The patient had always been dominated by her mother and had never been permitted to think for herself. Her husband stated that her mother always incited her against him, and that, although she had been trying to break away from her mother for years, she had never succeeded. In make-up, the patient was described as "moderately religious, a poor mixer, sensitive, shy, backward, and unable to carry on a conversation."

Three weeks prior to admission, the mother "removed a knife from the house because she did not think it was safe." The following morning the patient would not feed her child and complained of "gas around her heart." The next day she became very upset and refused to stay alone in the house with her husband.

She went to the police to swear out a warrant for his arrest and ran to his sister-in-law for protection. She rambled incoherently about her husband trying to hypnotize her and trying to take the child from her.

On October 30, 1947 she was taken to the Kings County Hospital observation ward where she was confused, agitated, rambling and irrelevant. She was actively hallucinated, and she expressed persecutory delusions directed at her mother and husband. "I was married to my husband legally. I was treated terribly by my husband and my mother. She treated me terrible. She's so different from me."

At Brooklyn State Hospital she was withdrawn, disheveled, underproductive and blocked. She said that she wanted protection from her husband because voices told her that he had another woman and would try to take the baby away. She admitted that her married life was full of quarrels but repeated, "My husband is a very good man."

On November 10 a letter was received from the husband asking that the mother be prevented from visiting at the hospital because, he asserted, she upset the patient and aggravated her condition. During this period V. C. frequently required restraint. She screamed bitterly about how she hated her mother and how her mother was trying to harm her. On November 21, 1947 electric shock therapy was started. It was discontinued on January 5, 1948 after 18 grand mals. She was somewhat improved at that time, but she was still noted to be dull and subdued, and she still expressed the fear that her husband was going to take her baby away. She expressed overt hostility toward her mother, declaring that her mother would not let her be free. She continued to be superficial, withdrawn and apathetic.

On February 10, V. C.'s mother died and almost immediately afterward the patient improved markedly. The following is a direct quotation from a note on her chart, made on February 24, 1948, long before the writers had any intention of conducting the present study: "Improvement dates back to the time the patient learned her mother died. At interview patient made a good impression. She answered questions relevantly and coherently. Says the mother bothered her and interfered with her married life. Says her mother died two weeks ago from a heart attack."

This patient was placed on convalescent status on February 25, 1948 and was seen every month until February 25, 1949 when she was discharged as recovered. She made a good adjustment and there is every indication that she has reverted to her pre-psychotic personality.

Discussion

Intensive study of these cases to ascertain the dynamic meanings to the patients of the deaths of the mothers was restricted in the patients' interests. The material was apparently repressed very quickly, and active probing was considered dangerous. However, it is felt that awareness of the phenomenon will lead to further observations which may elucidate the problems, and perhaps throw some new light on the nature of the schizophrenic process.

It seems reasonable to assume that maternal death was a significant factor in the improvement of these patients. Though frequently observed, such beneficial reactions are by no means universal. Many schizophrenic patients do not improve following maternal death. The writers examined the records of many whose

mothers or fathers had died during the course of their illnesses. In no case was there any apparent improvement following the death of a father, and many whose mothers had died remained actively psychotic.

The three cases presented are the only ones in which first-hand information was available and adequate; and in which there seemed to be reasonable justification for assuming a relationship between maternal death and improvement in mental condition. The factors which may be significant are:

1. All three patients were young, and were suffering from acute schizophrenic breakdowns of relatively recent onset. All represented first psychotic episodes. These factors usually indicate a favorable prognosis in schizophrenia.

2. In all three cases the mothers were actively involved in the delusional and hallucinatory systems. In Case 1, the illness of the mother preceding death appears to have been a significant precipitating factor in the psychosis. In Case 3, naked hostility and hatred for the mother was expressed during the psychosis. In Case 2, accurate information pertaining to the details of the patient's relationship with his mother is lacking. However, she was repeatedly represented in his hallucinations and delusions.

3. All three patients were dominated by their mothers. In Case 1 and Case 3, the mothers were described as openly domineering and aggressive, especially in their relations with the patients. In Case 2, although detailed information is lacking, the household and family organization appears to have been matriarchal, subtly dominated by an "emotional" and "high-strung" mother.

4. The presence of guilt in the writers' three patients deserves mention. In Case 2, the guilt was openly and violently expressed. In Case 1, the patient's exaggerated reaction to his mother's illness preceding death may be explained on the basis of guilt. In Case 3, detailed information concerning the patient's immediate emotional reaction to the news of her mother's death is lacking. In view of her tremendous overt ambivalence toward her mother, it is likely that she, too, reacted with feelings of guilt.

These cases seem to confirm the importance of the so-called "primary unit" or mother-child relationship in the genesis of mental illness, as emphasized by Benedek,[1] Rosen,[2] Klein,[3] and others. Tietze, in a recent study of the mothers of 25 schizophrenic patients, concluded that they were all domineering, either overtly or

subtly. All of them were over-anxious, obsessive and rigid in their attitudes toward sex.[4] This certainly coincides with the descriptions of the mothers in the present study, as well as with the impression gained from contact in general with the mothers of schizophrenic patients at Brooklyn State Hospital. It would be tempting to postulate a formula in which schizophrenia develops as a result of the influence of a grasping, domineering, alternately seductive and rejecting mother. However, the importance of these observations at Brooklyn is limited, since in the cultural milieu from which this hospital's patients are drawn (mainly "lower middle class," first-generation American families), the matriarchal family unit, governed by a "high-strung" mother, seems to be the rule rather than the exception.

In this cultural setting, the overthrow, or at least the diminution, of the mother's influence is usually a significant hurdle on the road to maturity and independence. It is apparent that the patients described here failed in their attempts to emancipate themselves from the domination of their mothers, and that these attempts reflected a basic conflict.

The acute psychoses in these patients seem to have represented flights from the temptations or frustrations offered by the mothers. It must be clearly stated that these patients are not "cured." Their personalities are still maimed by the same constitutional factors and narcissistic fixations which originally led to their psychoses. However, adaptation was facilitated by the establishment of a less irritating and provocative reality.

Summary

Three cases are reported in which patients made startling remissions from acute schizophrenic episodes shortly after maternal deaths. This is considered a frequent occurrence, although the literature apparently makes no reference to it. The mothers in all three cases were domineering, especially in their relationships with the patients, and they were all actively involved in the delusional and hallucinatory systems of the patients. Maternal death apparently made adaptation to reality more inviting.

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PRESUMPTIVELY TELEPATHIC INCIDENTS DURING ANALYSIS

BY JAN EHRENWALD, M. D.

It is a generally accepted principle of the scientific method that the less the degree of credibility of an hypothesis, the greater must be the weight of evidence on which the hypothesis is based. Applying this principle to the telepathy hypothesis, it is only fair to expect that anybody putting forward a telepathic interpretation of so-called spontaneous occurrences, such as can be observed in everyday life or in the psychoanalytic situation, should substantiate his claims with a great number of well-authenticated observations, i. e., incontrovertible data, accompanied by only a minimum of theoretical speculations.

However, in seeking to meet this requirement one must first take an important preliminary step: We have to define our terms and make it perfectly clear *what* it is that we are going to accept as *data* on which our argument is to be based—even though, on trying to do so, we may get involved in the very theoretical discussion which we are expected to avoid in presenting our case.

Telepathy has been defined as awareness by a person of another person's mental processes without the aid of the customary channels of sensation. This definition is incomplete on three counts. It leaves any reference to the time factor, i. e., to the implied simultaneity of the mental processes concerned, out of account; it fails to define the nature of these processes; and it contains no clues as to the criteria of their assumed telepathic correspondence.

One can forego, in the present context, the discussion of these largely philosophical problems. But to arrive at valid data regarding incidents under review, it is necessary to clarify the formal *criteria* by which an occurence's telepathic nature is to be determined.

There are three principal criteria which can be used for that purpose. First, it can be shown by the statistical method that an apparent coincidence or correspondence of two contemporaneous sets of mental events cannot be due to chance alone. The evidence arrived at in this way is then based on the results of probability calculation, i. e., on the criteria of *statistical significance*.

Second, a criterion can be based on the finding in each of the two sets of mental events under review of such a combination of

distinctive features or characteristics that coincidence due to chance alone can be ruled out of the question without resort to the mathematical method. This can be described as the criterion of *specificity* or *uniqueness* of the material concerned.

Third, the telepathic interpretation of the coincidence of two contemporaneous sets of mental events, in conjunction with collateral evidence derived from similar observations, may lead to what Bertrand Russell[1] described as a "consistent system of rational beliefs in which each part lends support to every other" part and thus may attain a high degree of credibility of its own. This can be described as the criterion of *psychological significance* of the observations concerned, viewed against the background of the beliefs held and the philosophical outlook prevailing within a given cultural pattern.

Rhine's statistical card experiments[2] at Duke University can be cited as examples of evidence of the first type. Some of the more recent observations of the present writer are instances of evidence based on the criterion of specificity, due to what the writer has described[3a] as the telepathic tracer-effect of certain well-defined items in the manifest content of dreams. Yet, the majority of the observations described by psychoanalytic authors are chiefly of the third order (Eisenbud,[4] Pederson-Krag,[5] Fodor,[6] et al.). They are less concerned with adducing data of high evidential value than with exploring the psychodynamics of the individual occurrences and with demonstrating their meaning and significance within the broader psychological context in which they occurred. (Ellis' failure to make allowance for this fact obviously accounts for the scathing criticism[7] he has levelled against them.)

That the psychiatrist and psychoanalyst cannot, as a rule, avail himself of the statistical method for evaluating his observations goes without saying. Likewise, evidence of the second type is a matter of the greatest exception. An occasional streak of luck may place a striking case in his hands. Such a case may then meet the criterion of high specificity or even uniqueness. But more often than not, the psychiatrist has to resort to the argument of psychological significance or consistency to support his case.

However, he may rightly be asked at this point to state with *what* system, if any, his observations then claim to be consistent; and by *what* standard, if any, he proposes to determine the psychological significance claimed. This is undoubtedly a crucial

question with which any systematic exposition of the telepathy hypothesis must come to grips. There is no use in denying that the introduction of the telepathy hypothesis conflicts with some of the basic propositions of our accepted body of experience. Indeed, telepathic phenomena seem to fall more in line with some of the magic or animistic beliefs of pre-literate peoples—if not in line with the delusions of the paranoid patient—than with our customary rational thinking. To avoid this embarrassing implication of the telepathy hypothesis, one may, therefore, easily be led to embark upon a full-dress theoretical discussion of the problems involved. This, as was said, is rightly to be discouraged at the beginning of a fact-finding expedition into unexplored scientific territory.

The observations that follow will show the difficulties inherent in such a fact-finding venture. The suggested telepathic nature of the incidents to be described is based in part on the criteria of *specificity* suggested by the tracer-effect of clearly distinguishable specific items, and in part on the argument of *psychological significance* or consistency with other observations of the same order. However, for the reasons already stated no attempt will be made to present a detailed account of the system of thought which would give added support to telepathic interpretation of these incidents.

Obviously, such a consistent picture can develop only step by step, as more and more corroborative evidence comes to notice. In the meantime, one must be satisfied with pointing to the areas of agreement which exist between the "orthodox" psychoanalytical and the "unorthodox" telepathic interpretation of the observations under review. Indeed, it will be for the reader to decide whether contrasting these two alternative interpretations is not purely arbitrary after all, and whether the original observations on which the psychoanalytic system is based have not themselves evolved from evidence of much the same order as that considered here.

Case Illustration

One of the writer's patients is a man of 31, a college graduate, suffering from an obsessive-compulsive neurosis. From the age of 11 or 12 he had had the fantasy of a strong woman beating a weaker one, a fantasy that had persisted until he started treatment. He had to ask his mistress whether she could "beat up" Mrs. X or Mrs. Y. He felt a compulsion to kick women he saw

in the street. He had to count compulsively the number of tiles in the toilet, or bricks on buildings he passed. At the same time, he showed the perfectionist tendencies well known in personalities of his type.

He was unmarried and greatly devoted to his mother who, he said, advised him against marrying a divorced woman with whom he had an affair. He was erectively potent but had to resort during intercourse to his fantasy about women fighting.

In analysis he produced a wealth of thinly-disguised incestuous material. He dreamed that he had done wrong, that the police were after him and that he had taken refuge in his mother's house. In another dream he was struggling with three rattlesnakes, with the scene shifting to a big blustering man who was "beating up" men and women in a train. The patient did not dare to resist him.

The snake motif returned in many subsequent dreams. In one, the patient wanted to capture the snake hidden in the grass but he was barefoot, and so it was too dangerous to try. He blamed his father who did not buy him shoes. In the same dream he saw a huge fat fish, three times his own size, lying next to the snake. The fish reminded him of his mother.

Despite the fairly obvious meaning of most of the material produced during the initial stage of treatment no interpretations were given to the patient. Analysis was largely confined to his ambivalent attitude toward his father and the way in which this was reflected in the transference relationship.

Other dreams represented his father—much in the same light—as the big blustering man who "beat up" people on the train. The patient was supposed to box with him. Their boxing gloves had gotten stiff from lying in water. They softened them, but the patient was suspicious as to whether his opponent had really gotten *his* gloves soft.

Boxing and wrestling had been his hobbies up to the age of 14. At that time he decided to give them up because the thought of hitting people had become revolting to him. He had been a rough and boisterous youngster, a member of a tough street gang, given to cruel and sadistic pranks. At 13, while "wrestling" with one of his friends, he suddenly stopped hitting him because he was overcome by scruples. From that time, he was only a boxing and wrestling fan, dreaming how wonderful it would be to show off his muscles but refraining from any active sports. Gradually he with-

drew from the street gang, became a voracious reader and became increasingly interested in abstract philosophical problems. When he started analysis, he had already read a great deal of analytic literature.

In contrast to his powerful physical build, this patient was meek and submissive, overpolite toward the therapist. He would never protest a change of appointment, and it was only after several months of treatment that he was able to express impatience over what he felt was the slow progress made, or to give vent to any aggressive feelings toward the analyst. He felt greatly relieved when he could see how his aggressiveness was linked up to his resentment of his "big blustering father." He remembered that as a child of two or three he was horse-playing with his father in bed and urinated on his head. More memories of this kind followed, mobilizing the patient's castration fears.

Dream: I broke my upper jaw when I played football or baseball. Some man was to set it. I insisted it should be Dr. C. or Dr. G., but they were too busy. I could not find anybody to do it. It got worse and worse, and so I had to pull out my front teeth.

After three or four months of treatment he was able to express much of his repressed hostility. It was directed in part against his father and uncle in whose fur business he worked as a junior partner, drawing a salary. In part it was directed against the therapist whose role as a father substitute had already become clear to the patient. For several months he produced an increasing mass of oral and anal sadistic material to which he responded with more and more undisguised castration dreams and fantasies. After a transient phase of increased anxiety during which he altogether lost his potency his condition showed a marked improvement. He had no longer to resort to his sadistic fantasies during intercourse, and his potency showed considerable improvement. At about that time he decided that he would end the partnership with his father and uncle and go into business on his own.

In view of this favorable progress I hinted that his treatment might be terminated sooner than expected without, however, specifying a date for the termination. As a result of this casual remark the patient seemed to pass into a new phase of resistance, expressed by a profuse flow of sadistic fantasies and other pre-genital material. At the same time he professed to be overjoyed by the contemplated early termination of analysis. Nevertheless, he

was himself doubtful as to his ability to stand on his own feet. He knew enough about psychoanalytic theory to wonder whether he had recalled and worked through sufficient early infantile memories and other unconscious material to be safe from a relapse. He tried to recall more of this material in his usual compulsive way but produced little of analytic interest or true therapeutic value. At the same time, he became increasingly aware of the homosexual aspects of his positive transference to the analyst and of his dependence on his father, as well as of the connection between his passive feminine identification and the fantasy of the strong woman.

It was at this time, in the tenth month of the treatment, that a series of observations of an apparently telepathic nature was recorded.

Dream: A man was fixing our cellar. He made a window for the cellar bathroom to let in light and fresh air. I thought the window would be too large. Then I thought: No, it would rather be too small. Finally I thought it would be alright. I felt I owed the man something for his labors. I thought I would let him have a fur coat at a reduced price so that I could show him my gratitude. But I could not do it because of my father.

The rest of the dream contained another variation on the theme of his resentment of his father and is irrelevant in the present context. The cellar reminded him of his unconscious; the bathroom, of the wealth of anal material produced in the course of the treatment. Letting in fresh air and light, therefore, referred to his analysis. The man who fixed the cellar was the analyst. The patient had no associations connected with the size of the window. With reference to the fur coat, he complained that his father and uncle had never given him a chance to sell fur coats to his friends at reduced prices.

These associations make the meaning of the dream obvious. It expresses his appreciation of the treatment, his wish to show his gratitude to the therapist—although the resentment expressed in the second part of the dream (not reproduced here) also shows the ambivalent nature of his transference.

As usual in dreams suggestive of the operation of a telepathic factor, more light can be thrown on its latent meaning by paying attention to the psychological situation on the writer's "end" at the time the dream occurred. On listening to his account of the

fresh air and light that was to be let into the *cellar,* the writer was struck by the close correspondence of the remark with what he had said the day before to the engineer who was to install an air-conditioning unit in the office. The writer remarked to him that it was very much like a *cellar* with very little *air* and *light* coming in so that it would not require installation of a large unit. The writer expressed concern, though, that its only *window* would be still more *reduced in size,* making the room darker than before. The engineer gave assurance that this would not be the case; on the contrary the window would look *larger* than before. When the man left, the writer and his wife (who works as his secretary in the office) laughed at this rather insipid piece of sales-talk. But the writer remarked that he obviously referred to the operation of the fan, which would bring in more air in winter than could be let in through the partly-open window. Since artificial light was used most of the time, the reduction of the daylight coming through the window would not make any difference after all.

It must be added here that the dream occurred on a Thursday night, in the middle of May 1949 and that the unit was to be installed on the day following the Friday session with the patient, i. e., on Saturday. As indicated, the conversation with the air-conditioning representative took place on Wednesday.

Needless to say, the prospect of having such a unit installed in the office had given the writer quite a thrill. Indeed, the thought of it may have occupied his mind during the preceding days to a greater extent than anybody concerned over his professional dignity would like to confess in public.

The motif of the *fur coat* leads to another, not less embarrassing trend of thought. With the coming of spring, the writer's wife had expressed the wish to have an old fur coat remodeled, preferably by the firm with which the dreamer-patient had been connected. The writer indicated to her that asking a patient for such a favor was out of the question, but agreed that she might turn to him once the treatment was terminated. She had first brought up the matter about three weeks previously, but two or three days before the dream occurred, the writer told her that "Mr. N." was indeed making good progress so that her "dream" referring to a remodeled fur coat may actually come true in not too distant a future.

It must be emphasized at this point that neither the writer nor his wife had made any reference to the matter in front of the patient. Nor had the patient any inkling about the proposed installation of an air-conditioner in the office. This is all the more important to bear in mind, since in the session preceding the one on which he had related the dream, he had made another—this time open—reference to an air conditioner quite out of the blue.

At that period of the treatment, the patient was in the habit of starting the session with a long string of trivial associations, referring to objects seen in the room, to the analyst's wife's appearance, etc., interspersed with the monotonous recital of his obsessive-compulsive fantasies of anal-sadistic nature. It was in this chain of seemingly incoherent associations that he suddenly referred to a small electric heater, which he had become sufficiently familiar with in the course of the preceding months, as an *air conditioner*. The writer recorded his slip without commenting to him on what had already—on that first occasion—appeared a curious coincidence with the writer's own preconscious preoccupation with exactly the same matter at the same time.

In the fourth session following the incident just described, the patient produced what appears to be another telepathic reaction. Starting his chain of associations in his usual manner he said among other things: "Dirty chair . . . Kicking you . . . Your wife has golden teeth . . . *She has new shoes today* . . . When will this end? etc." The writer at first paid no attention to his remark about his wife's new shoes, but, after the patient left, asked her about them. She was surprised. She actually had bought a pair of new shoes prior to coming to the office at 2 p. m. She did not wear them, or even unpack them, but put the box down in a small treatment room not directly connected with the office, out of the patient's sight and, indeed, inaccessible to him. The patient had his session at 3 p. m. and had neither seen her on her way, nor had he met her accidentally while she was shopping. The writer, on his part, had been likewise unaware of what happened and had not known that she was planning to buy shoes. Unless we choose to attribute the patient's reaction to the familiar *deus ex machina* called chance, it may therefore again well be attributable to telepathy, this time from the analyst's wife to the patient. It will be noted that the same considerations can be applied both to the air

conditioner and to the fur coat motifs that were involved in the previous instances.

The possibility of a joint telepathic agency involving the writer as well as his wife is also to be considered in the following incident. The patient described a dream in which he was told by a doctor that he was suffering from anemia. This set into motion a chain of associations part of which runs as follows: "Anemia . . . Only sissies have anemia . . . blood . . . blushing . . . *oilcloth* . . . why do I think of *oilcloth* . . . is it psychic again? . . . oilcloth in cellar . . . dogs' feces . . . My mistress can beat up your wife . . . *oilcloth* again . . . oh, I have got stuck on *oilcloth*. Is it a psychic vaudeville act? It sticks in my mind like a piece of glue . . . it is dirty . . . (What shape?) Diamond shape . . . about one foot in diameter . . . It's like a rag . . . I visualize it like a leaf dangling in the wind, it hangs on something under the *sink* . . . it's dirty gray."

On the same day, the analyst had acquired a small box-shaped wooden foot-rest for his own use in the office, and was quite pleased with the added comfort it meant. It had a polished surface, and the therapist asked his wife to procure a piece of *linoleum* or *oilcloth*, cut to size, with which to cover the footrest. He must confess that, while listening to the patient's monotonous recital of his compulsive thoughts, his mind had wandered to the oilcloth which would have helped to relieve his feeling of fatigue at that time.

When the incident was related to the analyst's wife she supplied an additional piece of information. She had remembered an old sink-mat which she had replaced by a new one some time ago. Instead of throwing it away, she had pushed it between a kitchen cabinet and the kitchen wall where it had remained since. She had been wondering whether, when cut to size, it would not serve the purpose of the piece of oilcloth the writer had asked for. The writer must insert here the fact that he knew nothing of the whereabouts of the sink-mat—although there is a possibility that lining the footrest with it may have crossed his mind independently of his wife's. It will be noted that the patient's reference to a dirty rag suspended in some way from a kitchen sink and to its implied vertical position ("dangling like a leaf in the wind") suggests that here, again, the wife rather than the writer may have played the part of the agent.

The last incident in the series occurred on July 7, 1949. The patient reported the following dream: Someone was buying a fur coat, and she could not make up her mind whether to take the cheaper or the more expensive one. She asked me to tell her which one to take. I told her the good qualities of both coats.

The buyer of the fur coat reminded him of a German woman refugee, a psychiatrist's sister-in-law. She was promised a fur coat after her first child; and she and her husband had consulted him a few years before about what coat to choose. He was pleased that they had turned to him and not to his father. This showed him that they had more confidence in his than in his father's expert advice. These associations led back to the transference relationship. The patient's dream obviously expressed his desire to be in the therapist's place, the therapist again representing his father.

This interpretation is further borne out by the psychological situation at the writer's end. As it happened, on the evening preceding the dream, the analyst had a consultation with a new patient, a German refugee woman whom he had first seen a week ago. She was suffering from an acute exacerbation of an obsessive-compulsive neurosis and could not make up her mind whether to start treatment. On July 6, 1949 she had come to see the writer in great excitement. She had to choose between two apartments which were offered to her: a cheaper one in 97th Street and a more expensive one in 95th Street. The writer had to discuss with her in great detail the advantages and disadvantages of the two apartments and their respective locations. The analyst got more involved in this discussion than he thought was advisable as a preliminary to analytic treatment, and tried hard to avoid the responsibility of giving straight advice one way or the other.

It will be noted that the first patient's fur coat dream seems to duplicate the writer's own situation in five ways: (1) It contains a reference to an expert who is being consulted by a customer (patient); (2) the advice sought refers to two alternative choices, involving a cheaper or a more expensive item; (3) the pros and cons are equally divided between the two choices making a detailed discussion of their qualities necessary; (4) in both cases it was a German woman who could not make up her mind; (5) both were "related" to a psychiatrist.

Nevertheless, it may well be objected that the four or five elements that are presumed to be common to both dream and corre-

sponding real event are not specific enough to warrant a telepathic interpretation. It is at this point that the criterion of psychological significance or consistency can be resorted to in support of the telepathic thesis. The dreamer, giving advice to his customer regarding the fur coats, quite obviously assumes the role of the therapist. He does exactly what the latter was called upon to do on the evening preceding the night on which the dream occurred. (The writer's records show that the German woman had consulted him about her apartment as his last patient at 6 p. m.) Indeed, it has become sufficiently clear from the brief report of his case that identification with the therapist had become an important feature of the patient's attitude at that stage of the treament.

Thus the telepathic interpretation of his dream is not only in good keeping with the orthodox analytical reading; it furnishes additional clues in the same direction and, as it were, clinches the case. The writer may recall that in a number of dreams studied by Eisenbud,[4] Pederson-Krag,[5] and Fodor,[6] as well as by the present writer,[5b] it was only through proper appreciation of the telepathic factor involved that their latent meaning had become apparent.

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It may be as well to sum up the five apparently telepathic incidents described so far. In the first instance, a telepathic factor seemed to be involved in the manifest content of a dream. Besides obvious references to the transference relationship, it contained three specific items that showed close correpondence to what had been the writer's own emotionally-colored thoughts at the time the dream occurred. There was, first, reference to letting *light* and *air* into the *cellar;* second, to the *size* of the *window* through which that was to occur; third, to the writer's repressed desire to ask the patient for a *favor* in connection with the writer's wife's *fur coat.*

It will be noted that in this instance, as in the last dream of the series, it is the combination of several elements and their correspondence with a number of likewise interlacing elements in the analyst's own mind which is suggestive of the dream's telepathic nature, even though the telepathic interpretation of this first dream may be of lesser psychological significance to the over-all picture presented by the patient than in the last instance.

The three waking incidents are much more trivial and elementary and, therefore, of much lesser evidential value than the dream

reported here. To the skeptic the patient's unexpected reference to an as yet non-existent air conditioner may certainly appear less striking than to one who had already been expecting arrival of the conditioner with impatience. (The writer hinted that its proposed installation had been a matter of a more intense preoccupation to him than he liked to admit in public.) The same is true for the incident involving his wife's new shoes. It should be noted, however, that in this case, not the writer, but his wife had to be considered as the telepathic agent—provided that we are altogether satisfied with the telepathic nature of the case.

The fourth incident, trivial though it be, is unusual in that the patient himself was struck by his compulsive perseveration in such a far-fetched idea as an oilcloth dangling in the wind. He had the distinct feeling of its extraneous, heteropsychic origin. It is true that by then he had himself become alerted to the possibility that a telepathic factor may have been intruding into the relationship with the analyst. This may indicate that his own puzzlement at what he called the psychic vaudeville act that he was playing should be taken with a grain of salt. On the other hand, here again, the coincidence with the analyst's own preoccupation with the same idea at the very same time is striking enough.

In trying to assess the pros and cons regarding the telepathic nature of the five incidents described, yet another factor has to be taken into consideration: the serial incidence of the occurrences within a limited space of time. The writer has indicated that they occurred in the course of four sessions between the middle of May and the first week of July 1949, at a time when the patient had been seen twice a week. Two of the incidents occurred during the same session. Further, this serial incidence of apparently telepathic occurrences must be considered against the fact that, during the preceding 10 months of treatment, no observations suggestive of telepathy had come to the writer's notice in this patient. Neither has he observed any more such incidents following the series just described.

Last, it should be recalled that the fifth telepathic incident, dovetailing as it does with the psychodynamics of the case presented here, lends added support to the telepathic interpretation of the whole series, even though the evidential value of the occurrences taken by themselves may be unequal and may fall short of what

the writer has described as the criterion of uniqueness as applied to telepathic phenomena.

But the present account would be incomplete without relating another observation which seems to have started the series just discussed. On April 11, 1949 at the end of the session, the patient made a casual remark about warts which he had had for several years on his right hand. The writer was greatly interested at that time in the psychosomatic aspects of verrucae and had just been studying the pertinent literature. Actually, he had prepared a brief extract of references from the German literature for a friend who had started a research project about suggestive and hypnotic treatment of warts. The patient's remark came too late for the writer to ask more particulars about the warts during the same session. But the thought had crossed the analyst's mind that experiments of this kind would be well worth while in a patient with whom the analyst had established good, personal rapport and the psychodynamics of whose personality had become familiar to him. At the same time, the writer had dismissed the idea with a melancholy sigh, as it were. He felt that it was to be one of the many research projects which for lack of time he had to leave for others to pursue.

Yet, a week later, in the session on April 18, 1949 the patient reported a dream, saying that *"the warts had come back."* When asked to explain the dream, the patient said that he had had two small warts on the volar aspect of the middle and ring finger of his right hand and a big twin wart on the palm of his right hand. He said that the two warts on his fingers had disappeared during the past week or so and that only the twin wart on his right palm had remained. He showed the places on which, according to him, the warts had been located prior to their disappearance. The writer could see what appeared to be superficial epithelial defects on the spots indicated by the patient. They may or may not have been the last traces of what was left of the warts. There is no need in the present context to discuss in more detail the presumable meaning of this dream in terms of the patient's castration fears.

Since, unfortunately, the writer had missed the opportunity of convincing himself of the warts' existence, he sought to obtain an affidavit from the patient's mother concerning his statement. The

affidavit, as reproduced here,* is unsatisfactory inasmuch as it is indefinite as to the exact time of the disappearance of the warts. The whole wart incident cannot, therefore, be regarded as anything like scientific proof regarding an assumed telepathic effect of the analyst's emotionally-colored—yet repressed—therapeutic motivations aiming at suggestive treatment. The possibility cannot be ruled out that the warts were no longer there when the patient first mentioned them to the analyst. Further, it is possible that, despite the analyst's failure to verbalize in any way his interest in the matter, he may unwittingly have imparted some inkling of it to the patient, and that he, in turn, may have unconsciously connected certain expectations with his own remark—thus setting into motion the chain of psychosomatic events that ultimately led to the disappearance of the warts, without involving a telepathic factor.

However that may be, it goes without saying that the incident itself may well have provided just that emotional impetus in the mind of both therapist and patient which, from all we know about the conditioning factors favoring telepathy in general, may have paved the way for the subsequent series of more conclusively-telepathic incidents.

* * *

What, then, is the significance of these observations? If we are satisfied with their telepathic nature, they seem to throw fresh light on a new set of conditioning factors for telepathy in the psychoanalytic situation. The part played by positive transference in a broader sense is too well known[3] to need further elaboration. It provides, among other things, that degree of *rapport* which seems to be an important—though not necessarily indispensable—prerequisite of telepathic occurrences.

The writer's own emotionally-colored preoccupation with what he first—rightly or wrongly—considered the patient's telepathic reaction involving the wart incident may have supplied another conditioning factor. It may best be classified under the general heading of the therapist's counter-transference to his patient.

*This note is to verify the fact that my son, N. N., had three warts, one on the palm of his right hand and two adjacent to each other on his second and first finger of his right hand which disappeared during his analytical treatment sometime in April, May or June 1949. I can remember these warts for at least three years previous to 1949.

Mrs. N.

A further factor may have been the patient's greatly enhanced desire to co-operate with the therapist, to please him with the production of just such analytic material as he intuitively felt would arouse his special interest. He was told that the treatment might draw to a close sooner than expected. From his earlier wide reading in the field of psychoanalysis, he had learned that the patient was supposed to remember and to bring up as many early childhood recollections as possible. He had actually made repeated references to that effect during that period of treatment. He also knew of the therapist's interest in the problem of telepathy and had actually read his book about the subject before commencing treatment. Although no mention of the matter had been made during the further course of analysis, it may well be that the wart incident—which the writer had discussed with the patient in terms of a possible case of "autosuggestion"—had evoked in him the desire to do better next time at what he himself had called his psychic vaudeville act.

As far as the recall of early infantile material is concerned the patient had produced no new recollections and continued his acting out on an oral and anal sadistic level for several more weeks. In short, he passed into a new period of resistance, indicating that he was not ready as yet to terminate treatment. Viewed against that background of resistance, it may well be that *offering telepathic, i. e., heteropsychic experiences of a more harmless and trivial nature had served him as a convenient substitute for material which he could not face.*

However, closer study of the patient's productions at that time shows that the isolated telepathic incidents described were in effect interspersed in material of just that resistive order. It has been indicated that some of them occurred while he was reciting his compulsive thoughts referring to kicking, biting, sucking, defecating, etc., even though the recitation was not accompanied by the corresponding affects. It will be noted that this dissociation of affects, well known in compulsion neuroses, is at the same time a characteristic feature of schizophrenia. This is all the more significant if the writer recalls at this point his earlier observations about occasional telepathic occurrences in the associational content of deteriorated schizophrenic patients. The telepathic reactions seen in this group were in many respects similar to those produced by the compulsion neurotic discussed here.

The rambling "word salad" of one of the writer's schizephrenics[5] contained striking allusions to the writer's thoughts connected with her *Jewish appearance;* with the idea of *make-up* which had struck the writer in a girl confined to the refractory ward; to a *bottle of ether* with which the writer had been experimenting at that time, etc. All this was thrown into a chaotic welter of deeply-regressional material of autopsychic origin that formed the overwhelming majority of her utterances.

What, then, is the common denominator in the compulsion neurotic discussed here and the schizophrenic described in the writer's earlier observations? Obviously, it is the removal of a barrier which permits the emergence of heteropsychic experiences in both instances. In the first case, their break-through was due to the temporary weakening of the barrier, affecting only limited areas of the ego and was possibly helped by the release of early infantile material encouraged at that period of the treatment.

It will be noted, however, that what might be described as the ratio $\frac{\text{autopsychic}}{\text{heteropsychic}}$ material was about the same in both instances. By contrast, in the schizophrenics described, the breakdown of the barrier affected all areas of the patient's ego; it was of a global nature. What happened in these cases was not a limited intrusion of primitive regressional material. The patient's ego was totally engulfed by the "return of the repressed." But this should not obscure the fact that here, again, the demonstrable heteropsychic telepathic elements were only a fraction of the total repressed material that had broken through the boundaries of the ego. (It may be added, by way of a footnote only, that in genuine "psychics," the hypothetical ratio $\frac{\text{autopsychic}}{\text{heteropsychic}}$ experiences may be considerably smaller. If one can give credence to reports about certain spectacular trance manifestations in a few high-class mediums, it may occasionally become < 1.)

There is another important aspect of the psychodynamics of telepathy which is being brought out by the present patient. It was indicated that in two of the telepathic incidents described, his telepathic sensitiveness was not confined to influences emanating from the therapist. He seemed to reflect emotionally-colored elements which were either exclusively or preponderantly derived from the therapist's wife. If this is true, it must be realized that

the psychoanalytic situation, despite its closely-guarded privacy, does not operate, as it were, in a watertight compartment. The patient-doctor relationship, besides being determined by the dynamics of transference and counter-transference—including the occasional two-way leakage of heteropsychic material—may be further complicated by telepathic leakage from other persons: in the present case by leakage from one whose close relationship to the analyst was well known to the patient and whose role as a mother figure had repeatedly been discussed in the course of the treatment.

The writer may recall here his discussion[3b] of the identical problem in relation to telepathic influences that may be brought to bear upon a schizophrenic patient from outside the controlled hospital environment. But it goes without saying that in the absence of sufficient information as to the personalities of such potential external agents that may intrude in the psychoanalytic situation, there is no conceivable way by which further systematic research in this direction could proceed at the present moment. However, the telepathic leakage seen in the present case shows that the therapist must always be aware of such a possibility. Indeed, he would do well to realize that the classical concept of the doctor-patient relationship, operating within an isolated system according to the formula *transference-counter-transference,* is no longer tenable. It has to be replaced by the concept of a vastly expanded field of heteropsychic influences which may or may not impinge on both patient and therapist and thus modify the psychoanalytic situation.

This is but one of the conclusions that suggest themselves from the telepathic interpretation of the incidents described here. The potential part played by a telepathic factor that may be involved in the psychotherapeutic process itself was discussed in a recent editorial in this journal.[4] It is the object of a special study in a forthcoming article by the present writer.[5a] The writer may also recall his earlier references elsewhere[5c] to the potential effect of telepathic leakage—due to the analyst's unconscious expectations and pet scientific theories—upon the development of views held by the rival schools of psychoanalysis.

However, in seeking to formulate some of the conclusions that can be drawn from observations of the kind reviewed here, we are led back to the dilemma indicated at the beginning of this article: A relative paucity of factual evidence with too much emphasis on

theoretical implications may easily vitiate scientific cogency. On the other hand, our failure to demonstrate the consistency of the newly-elicited data with a meaningful theoretical system would deprive us of an important argument in their favor.

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A RORSCHACH STUDY OF A GROUP OF MEDICAL STUDENTS*

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Introduction

A study of the Rorschach patterns of medical students has been undertaken as a part of a broad investigation concerning the hereditary, physiological, and psychological characteristics which may precede the development of hypertension and coronary artery disease. The authors' purpose has been to search for certain factors which have been thought by others to distinguish the "pre-hypertensive" or the "pre-coronary" individual among a large group of normal young adults, and to measure and tabulate other factors which may be shown to be precursors of these forms of cardiovascular disease, as well. A number of studies[1, 2, 3] have been made concerning the personality of patients with hypertension or coronary artery disease after the disease process had been clearly established; most of these investigators indicated that the characteristic personality patterns described by them were already present in the patients' youth, long before the appearance of clinical disease. To the best of the writers' knowledge, no investigation comparable to the present one has been conducted to determine the presence and incidence of such traits in a substantial segment of the normal population of young adults.

Medical students were chosen as subjects for the general investigation because they present unusually excellent qualifications for the study. As a group, they closely approximate the age of full adult maturity, when adolescence and growth are virtually complete and degenerative changes are at a minimum; they are cooperative and available for intensive study; and, perhaps most important, they are in a state of bodily vigor and mental health compatible with the pursuit of the arduous medical school curriculum.

To analyze the subjects effectively from the psychological point of view, Rorschach's test was chosen as one of the main avenues of approach because of its breadth, and objectivity, and because it has been sufficiently standardized to render it susceptible to statistical analysis. It was planned to carry out individual Rorschach

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tests upon the several hundred subjects entering the general study. In interpreting them, it soon became apparent, however, that while the group under investigation was in many respects similar to other groups of superior adults previously studied by the Rorschach technique, there were certain differences which suggested that medical students, as a group, were distinctive. Before analyzing the individual Rorschach tests, therefore, the statistical analysis of the traits of a representative group of co-operative subjects was undertaken, and this is embodied in this paper.*

A search of the literature reveals only a few studies of superior adults which include subjects so well matched in age, intelligence, educational background and professional training as the group of Johns Hopkins medical students available for this study. Beck[4] studied a group of 39 very superior individuals, all but two of whom had professional backgrounds. No complete statistical analysis of the Rorschach records of this group was given, however, since the study was primarily concerned with a procedure utilized in determining configuration tendencies (Z scores). Further reference to the same group was made in a later publication by Beck.[5] Beck's control group in his study of schizophrenics[6] consisted of 81 normal subjects, only seven of whom were very superior in intelligence. Sixteen were superior, and 26 were of high average intelligence. However, the data for this group were combined with 22 records of average, and 10 of low average intelligence. Further reference to the various types of Rorschach patterns of healthy adults of superior intelligence was made by Beck in his original monograph on the Rorschach test.[7] No statistics were given in this reference, however. The group was described in terms of the relative quantity in which the various Rorschach components occurred: "High," "Medium," "Low," "Variable." In another study by Beck[8] very superior and superior adults were described in the same manner with regard to F+, Z, M, and ΣC.

McCandless[9] compared the Rorschach protocols of 13 pairs of highly superior men. Intelligence was measured by the Army General Classification Test which indicated the average scores to be 1.75 S. D. above the national mean. Although the author was primarily concerned with quantitative Rorschach differences between these pairs of subjects in predicting academic success, the

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means of the various Rorschach determinants for this group of highly superior men were presented. The Rorschach protocols of 50 college men and 50 college women were studied by Harriman.[10] However, their superiority can be inferred only on the basis of their college status. No psychometric ratings for the group were presented. In comparing differences in personality structure between two racial groups, Hunter[11] analyzed the Rorschach records of 100 white and 11 Negro college students. Munz[12] studied the Rorschach protocols of 28 male intellectuals. The statistical findings for this group were cited by Vernon.[13] Rorschach findings of 90 male college students were reported by Vernon.[13] Rorschach findings on a group of English university men and women were reported by Oeser[14] in his experiments on the abstraction of form and color.

Various studies have been concerned with the Rorschach records of different professional groups. Waggoner and Zeigler[15] studied Rorschach records of 148 freshmen medical students at the University of Michigan. Their psychometric study, ostensibly devised for screening purposes, included the administration of an individual Rorschach examination, but no statistical report on Rorschach findings was included in their article. Kaback[16] administered group Rorschach tests to 150 students in the schools of pharmacy and business at the University of Buffalo. The primary purpose was to examine the protocols in relation to vocational guidance principles. Artists and painters were studied by Prados[17] who analyzed the Rorschach records of the 20 subjects included in this group. Roe[18] administered the group Rorschach to 16 scientists and technicians who were all members of a Society of Vertebrate Paleontology; basic Rorschach data for the scientists and technicians were given. Roe,[19] again employing the group method of presentation, also studied personality structures of 188 biologists of eight universities. This study included a comparison of the Rorschach variables appearing in subjects specializing in the fields of biology, anatomy, botany, bacteriology and physiology.

The results of the studies referred to are discussed in the body of this paper, and their relationships to the findings of this investigation are indicated.

Subjects

The group of subjects chosen for the present study comprised the 60 members of the class of 1948 who co-operated in taking an

individual Rorschach test during their fourth year in Johns Hopkins Medical School.* They may be further described as follows:

Age. The mean chronological age was 23 years, nine months, with a standard deviation of 22.6 months. The youngest student was 21 years, one month old; the eldest 30 years, six months.

Sex. All but four of the subjects were male students.

Intelligence. As noted in Table 1, the students as a group were of very superior intelligence with a mean full scale Wechsler Bellevue (Form I) I. Q. of 131. The data of intelligence are based on the scores of the 47 subjects from the total group of 60 who received Wechsler Bellevue tests. From these data, the superior intelligence of the entire group is indicated since the students taking the Wechsler Bellevue test were selected entirely at random, without reference to their intellectual capacities. The difference between the verbal and performance I. Q.'s is consistent with expected findings in the general population of an adult group of superior intelligence.[20]

Table 1. Wechsler Bellevue (Form I) I. Q's of 47 Medical Students

	Mean I. Q.	SD	SEm	Range
Verbal	134	6.51	.94	117-148
Performance	121	8.90	1.30	97-139
Full scale	131	6.45	.94	117-148

Education. Since all the subjects were tested during their fourth year of medical school, the group was uniform as to medical school education. These students had entered medical school during the war years, when entrance requirements had been reduced. As a result, there was a greater variation in pre-medical educations than is found in the usual peacetime classes.

Health. None of the subjects studied had clinical hypertension or coronary artery disease; all were in good general health. No attempt was made to determine the incidence of neurotic tendencies within the group by the interview method. In fact, other sources of psychiatric knowledge of these subjects were purposely withheld from two of the present writers who carried out the Rorschach analysis (H. B. M. and E. E. M.), in order to keep this phase of the study free from bias.

*Of the 21 remaining members of the class, five have subsequently taken the test, others were unable to take the test at the end of the year because of busy schedules or examinations, and still others were frankly un-co-operative.

Procedure

The Rorschach protocols for each of the 60 subjects were administered individually by one of the authors (E. E. M.)* in full accord with the method outlined by Beck[21] Techniques of scoring were also based on the principles followed by Beck. Criteria for determining responses as F+ or F— were based upon Beck's norms and upon those listed in a manual of collected responses prepared by Brown.[22]

Results

The Intellectual Sphere

Productivity (R). A total of 3,300 responses was given by the group of subjects for the entire 10 cards. The mean R total was 55.37 with an SD of 24.0. The range in productivity was from 18 to 124 responses.

The group fulfills the expected level of productivity for that of very superior individuals. It compares exceptionally well with Beck's group of 37 very superior persons (professional level) where the mean R total was 52.30, the SD 23.8.[5, p. 58] A review of the literature on other superior groups indicates that Oeser's group of English university students is the only one which exceeded the present group with regard to productivity. Oeser[14] found the mean R for his 32 subjects to be 67. Harriman[10] reported a mean R of 52 for his group of 100 college men and women. The mean numbers of responses for various superior groups reported by Hunter,[11] Munz,[12] and Vernon[13] were appreciably lower than that for the group of medical students.** McCandless[9] reported a mean R of only 39.4 for a group of highly superior men who were also high in academic achievement in a United States Maritime Service Officers Candidate School. The 18 paleontologists studied by Roe[18] showed an unusually low level of productivity with a mean R of 21, responses ranging from 11 to 39. Her group of nine technicians included in the study were even less productive, their responses ranging from 12 to 26, with a mean of 18.2. It should be noted that the Rorschachs for her subjects were not given individually, but by the group method.

*Thirteen of the protocols were administered by Theodore M. Feldberg, whose assistance the writers would like to acknowledge.

**For the exact data derived from these studies, see Davidson and Klopfer (Ref. 23, p. 166).

In explaining the greater productivity of the present writers' group of medical students as compared with most of the other studies dealing with superior adults, we must keep in mind not only the various age, sex, and vocational differences, but the variability of R itself. It is true that intelligence and productivity are highly correlated, but affective factors also must be considered in relation to the R total. That the very superior individual who is cautious and on guard can constrict his productivity has been pointed out by Beck[5, p. 54] in his discussion of the response total. The large SD for the mean R in both the present study and in Beck's group of subjects indicates the great variability in productivity which may be expected within a group of very superior subjects.

Relative Productivity on Each Card. Table 2 ranks the 10 cards as to their degree of productivity. In the present group of medical students, Card X proves to be the most productive card in the entire series. Cards IV, V, and VII are the least productive when one considers merely the percentages of the total productivity they

Table 2. Productivity on Each of the 10 Cards for 60 Medical Students

Card	Total R	% of total R for 10 cards	Mean R	SD	SEm
X	514	15.57	8.5	3.68	.476
IX	366	11.09	6.1	3.20	.414
VI	334	10.12	5.5	3.04	.394
VIII	333	10.09	5.5	3.38	.437
II	323	9.78	5.4	3.17	.410
I	318	9.63	5.3	2.79	.361
III	315	9.54	5.2	2.77	.359
IV	290	8.78	4.9	2.75	.356
VII	265	8.03	4.4	2.58	.334
V	242	7.33	4.0	2.38	.307

comprise. However, when the more accurate measure of the reliability of the difference between the number of responses is noted (Table 3) it is found that this is not consistent for the entire group of 10 cards. No reliable difference between the productivity of Cards IV, V and VII is noted. However, from Table 3, it is apparent that Card V shows a significantly lower mean number of responses than any other card except III, IV, and VII. Moreover, the reliability of the difference approaches significance, even on Card III. Card IV is significantly less productive than Card X

only. Card VII, on the other hand, is significantly less productive than Cards IX and X. From these data, we may conclude that Card X is the most productive of the entire series, while Card V is the least productive.

Table 3. Reliability of the Difference Between the Mean Number of Responses on Each of the Rorschach Blots

Card	X	IX	VIII	VII	VI	V	IV	III	II	I
I	5.18*	1.27	.177	2.03	.187	2.89**	.987	.393	0	—
II	4.94*	1.20	.167	1.86	.176	2.67**	.921	.367	—	
III	5.54*	1.64	.530	1.63	.564	2.47	.594	—		
IV	6.06*	2.20	1.06	1.02	1.13	1.85	—			
V	7.88*	4.01*	2.75*	.817	2.94*	—				
VI	4.86*	1.05	0	2.13	—					
VII	7.07*	3.19*	2.0	—						
VIII	4.65*	.998	—							
IX	3.80*	—								
X	—									

Harrower-Erickson and Steiner[24] also listed Cards IV, V, and VII as the least productive in their group of 108 medical students. However, they did not determine the reliability of their findings, but merely listed the card in rank order according to the percentages of the total productivity they comprise. Gardner's data,[25] obtained from 100 normal adults of average I. Q., indicated Card V to be the least productive (7.24 per cent of the total 2,265 responses). However, Cards IV and VII compared favorably with the productivity of Cards I, II, and IX in his group. Card VI (7.59 per cent of the total 2,265 responses) was no more productive than Card V. His data indicate Card X to be the most productive card by a larger percentage than the present group (20.17 per cent of the total productivity). In eight of the nine groups studied by Harrower-Erickson and Steiner,[24] Card X was found to be the most productive, even in two of the groups who were categorized as prison inmates and psychotic and psychopathic subjects. Comparing the relative productivity on each of the 10 cards, as determined by these investigators, with the present group of subjects, then, it appears that lowered productivity on Card V

*The significant differences noted were in favor of the card listed along the abscissa of the table over the card listed along the ordinate.

**The significant differences noted were in favor of the card listed along the ordinate of the table over the card listed along the abscissa. (Critical Ratio = 2.58—P = .01—is taken as the level of significance.)

and increased productivity on Card X are not characteristics unique to this group of medical students.

It would seem that Card X is the most productive card primarily because of its structure. The larger number of individual details on this card permits the subject to interpret each of them separately. This supposition was substantiated by the lower number of W responses on Card X. In Gardner's group[35] 91 per cent of the responses on Card X were D, as compared with only 6.1 per cent of W. Rorschach himself noted that, "Whole answers are almost impossible" in Card X.[26, p. 52]

In the present study, Card X was found to elicit a greater percentage of D responses than any of the other nine cards, with the exception of Cards II, III, and VIII. (See Table 4.) The higher number of D responses in Card III must be considered in the light of differences of opinion about the scoring of W and D on this card. In the present study, W was scored in accordance with the requisites established by Beck; i. e., all details of the card must be

Table 4. Percentage of D Responses (Including Ds) of the Total Productivity for Each of the 10 Rorschach Cards

Card	Percentage of D responses of total number of R	Reliability of difference* of percentage of D responses, compared with Card X
I	43.1	9.03
II	67.5	1.90
III	86.7	4.78
IV	50.0	6.73
V	44.2	7.91
VI	60.2	4.08
VII	54.3	5.36
VIII	67.3	1.99
IX	63.4	3.24
X	73.7	——

*Critical ratio. P = .01 (critical ratio = 2.58) is taken as the level of confidence.

included and not the two popular figures alone. This same principle would hold in relation to Card II which does not show a reliably less significant percentage of D responses than does Card X.

In view of the results obtained in this study with regard to the productivity in each of the 10 Rorschach blots, care must be exercised in the interpretation of the significance of an increase in productivity in the last three color cards. On the basis of these

results, one may question the validity of Beck's opinion[5] regarding the ratio of the productivity in Cards VIII through X. According to Beck, "The ratio of this productivity is more significant than the percentage that the productivity in figures VIII to X forms in relation to the response total, since it provides an exclusive contrast between the two kinds of figures."[5, p. 82] It would appear from these findings that the practice of comparing the productivity on the last three color cards with that of Cards I through VII in terms of percentage of the total productivity, or in terms of Beck's ratio, as just described, must be considered critically in view of the fact that Card X facilitates more responses, not on the sole basis of its color, but upon the basis of its construction as well.

The rationale of overproduction in the last three color cards as an index of hypomanic excitation or a lowered threshold of hyperactivity to external stimuli is difficult to accept if this threshold for overproduction is based solely upon the percentage of the total productivity occurring in the last three color cards. Boehner and Halpern[26] indicate that if the number of responses on the last three color cards exceeds 40 per cent of the total productivity it implies that the colors increase mental energy; if fewer than 30 per cent of the total responses occur on the last three cards, withdrawal is indicated. The criticism of this method in dealing with the significance of such overproduction—based on the data derived from our study—is supported by Klopfer and Kelley[27] who also indicate that overproduction on Card X is "based on the particular facilitation of D in Card X rather than on the color which Cards VIII, IX, and X have in common."[27, p. 255]

The mean ratio of the productivity in Cards I through VII as compared with the productivity in VIII through X for this group of fourth-year medical students was .6208, with a standard deviation of .2010. These findings compare exceedingly well with those of Beck.[5, p. 82] who, on the basis of the ratio obtained, stated, "Thus, roughly, the ratio of productivity in the all-color figures to that in all the others should not be lower than about 0.40, no higher than about 0.85." Since the present study corroborates Beck's finding with regard to this ratio, its importance cannot be discarded, regardless of the fact that productivity in Card X is based, to a large degree, on its facilitation of the D response. Beck's ratio appears to be reliable for a normal superior group on the basis of the similar findings obtained in the present study. In view of the

increased productivity expected in Card X, because of its construction alone, the significance of a ratio higher than .85 as indicative of affective release still has to be considered questionable, especially if productivity on Card X contributes much more than Cards VIII or IX to the ratio. On the other hand, if the ratio falls below .40, it would assuredly indicate that affect is inhibited. Card X thus has an enhanced value in measuring any inhibition of affect, since an increase in productivity may be expected because of its construction alone. Consequently, if productivity is lowered in this card, a greater degree of affective inhibition would seem to be indicated. This would account for Card X furnishing an excellent means of measuring recovery from color shock. It reflects Rorschach's perspicacity in placing Card X last in the series.

Conscious Control: *Ego Strength* (F+%).—The mean F+% for the group is 86.16; SD 10.72. This compares favorably with Beck's findings in his control group where the mean F+% is 83.91; standard deviation, 8.12.[8] However, Beck[8] found the average F+% to be 75.20 in a group of 39 very superior healthy adults. This finding is appreciably lower than that for the group which comprises the present study. This average F+% which Beck reports for the very superior group is difficult to understand, since the mean average F+% of the control group in his study of schizophrenia[6] indicates a much higher F+%. Of his control group, 75 per cent was high average or above in intelligence (32.8 per cent rated as superior, 25 per cent as very superior, and 17.2 per cent as high average). Of his control group, 15.6 per cent were of average intelligence, while 9.3 per cent were considered low average. One would expect that a group consisting solely of very superior adults would have at least as high an F+% as his entire control group.

In a later control group of 157 normal subjects studied by Beck,[10] the mean F+% reported is 79.25, with a standard deviation of 10.20. The mean F+% for the present group of medical students is significantly higher than Beck's group of normal subjects.*

Vernon[12] with college students and Munz[13] with "male intellectuals," reported mean F+% findings of 79 and 83, respectively. Harriman[10] found a mean F+% of 78 for his group of American college men and women. Such studies as those of Oeser[14] on English university men and women indicated significantly lower F+%

*Critical ratio = 2.72, significant at .01 level.

findings. Oeser reported a mean F+% of 68 for his group of 32 English university students.

In comparing the various F+% findings of these studies, one must be aware that criteria for scoring responses as F+ or F— vary with the respective research workers. However, Oeser's results were so discrepant, one wonders as to the validity of the criteria he employed in the scoring of his responses.

Modes of Approach. (Ap).—The mode of approach was determined for each of the 60 records in the present study by the accepted procedure established by Beck. Table 5 shows the frequency for each type of approach. The important finding is the large percentage of cases in which there was an overemphasis upon

Table 5. Modes of Approach and Percentages of Occurrences in 60 Medical Students

	N	Percentage of total group
Normal (W — D — Dd)	12	20.0
W!	15	25.0
D!	7	11.6
Dd!	25	41.6
D! Dd!	1	1.6

the rare details (Dd!) of the test figures. In nine of the 25 subjects who followed the Dd approach, the emphasis upon Dd was slight. In the other 16 instances, however, the observed Dd was 1.8 or more times greater than the expected Dd for the total responses. The range is from 1.8 to 4.9, or more observed Dd than are expected, with an average of 2.5 times the number of expected Dd responses. The probability of a large number of these medical students showing obsessive-compulsive traits is suggested by these data.

Table 6 indicates the same tendency in this group to emphasize Dd areas. In a group of 157 normal subjects Beck[28] found the approximate limits of normal variability of approach to be: 16-22 per cent for W; 68-75 per cent for D; and 6-10 per cent for Dd. The mean percentages reported are 19.81, 17.94, and 8.23 for W, D and Dd, respectively.* From these data, it is thus apparent

*These mean percentages are computed for ungrouped data. The use of the frequency distribution introduces an error if there are frequent zero entries, thus violating the assumption that the mean of each step interval is at its mid-point. The mean percentages reported in Table 6 for the present study are computed from group data. Computing the same means from ungrouped data, the following values were obtained: W=18.46 per cent; D=63.50 per cent; Dd=17.81 per cent. The greatest difference noted is in the W% where more zero entries occurred when the data were grouped.

that this particular group of medical students emphasized the Dd areas at the expense of the D areas. Their W% fell within the

Table 6. W, D, and Dd Responses and Their Percentages of the Total Productivity for 60 Medical Students

	Mean		Standard deviation		Standard error of mean	
W	8.97	19.48%	5.76	12.03%	0.75	1.55%
D	34.25	63.50%	14.20	9.88%	1.85	1.01%
Dd	11.84	18.22%	12.90	13.74%	1.67	1.77%

range of Beck's 157 normal subjects, whereas their D% barely approached the lower limits of the range obtained for his normal group.*

In their mode of approach, the present group of fourth-year medical students would fall into two main groups with relation to their departure from the usual normal W—D—Dd expectancy: those emphasizing either W or Dd. In Roe's group of 18 paleontologists,[18] six, or 33.3 per cent emphasized W, only one subject of the 18 emphasized Dd. In her later study of 188 biologists, Roe found 25.7 per cent overemphasized W (Ref. 19, p. 39, Table 13.)** Also, an emphasis on Dd in 51.8 per cent of this group was noted.

Apart from Roe's study with biologists, other studies with superior groups already mentioned showed a much lower incidence of Dd responses than the present group. The mean Dd response of 6.1 in the group studied by McCandless[9] was among the highest mean number of Dd responses reported. The fact that this occurred in his "high grade point group" as compared with a mean number of 2.7 Dd responses for his "low grade point group" is of interest as to the effect emphasis upon Dd responses might have in relation to high scholarship.

*An important factor for consideration in comparing these statistics is that since the 60 records included in the present study have been scored, 13 of Beck's original areas have now been changed to D. The data reported for Beck's 157 normal subjects included these changes, whereas the data for the medical students did not. Four of these changes from Dd to D occurred in Card X, the most productive card of the group. The revised Dd% would hence be lower for these medical students, although the trend to emphasize Dd would still be present. Beck's earlier control group (Ref. 6) still had a much lower mean Dd% (5.62) based on his unrevised Dd areas.

**These percentages were derived by adding the number of cases, in each of the groups of biologists who overemphasized W% and Dd%. Although Roe referred to 188 biologists (p. 42), data for only 185 were given in her Table 13. The percentages given here were based on 188 cases.

Rorschach[29] presented the incidence of W at various levels of intelligence. For high average intelligence he expected seven to 10 W's; in the superior group, 10 or more. However, there was no mention of any psychometric measure upon which he based his classifications of intelligence. Beck[8] found the mean number of W responses in a group of very superior healthy adults to be 12.69. For his control group of normal subjects, 75 per cent of whom were of high average intelligence, or above, Beck[6] found the mean number of W to be 5.86. Harriman,[10] Hunter,[11] Munz,[12] Oeser,[14] and Vernon[15] all report consistently higher mean W scores for their superior groups.

Harrower-Erickson and Steiner[24] also found a large percentage of W responses in each of their four college groups. If we use the range of W% based on Beck's 157 normal subjects, all these groups overemphasized the W responses. The group of 108 medical students showed a mean W% of 37.0. This was much higher than was found in the group of students in the present study. These investigators employed the group method of administration and this may account for the differences noted. Hertzman[30] raised the question as to whether the group method does not result in more W responses. Also of interest is the fact that of the five groups included in their study, the highest incidence of Dd% was displayed by the medical students.*

Organizational Activity (Z).—The mean Z score for the group was 53.2 with a standard deviation of 28.49. If we compare it with the mean Z score of Beck's 157 normal subjects,[28] (22.48 with an SD of 14.91), the high level of organization in these medical students is readily apparent. The levels of Z established on the basis of this normal group are: low = 0 through 7.5; medium = 8 through 37.0; high = 37.0 and above. The present findings for Z compared favorably with Beck's findings for Z score in superior healthy adults.[7] Z scores of 50 and above were typical of his group.

There are few studies with superior groups in which an analysis of Z scores has been undertaken. McCandless[9] reported Z scores in his group. Of special interest is the fact that those of low

*No levels of confidence for the significance of differences in Dd% between groups were given. The group of art students were second to the medical students in the quantity of Dd%. This comparison was based only upon the descriptive statistics reported.

scholarship obtained a higher mean Z score (48.5) than his high scholarship group (43.3). This failure of the Z score to discriminate between good and poor academic achievement is surprising, since Z is an index of intellectual energy and a measure of intelligence-functioning in itself. One would expect that the trends toward more anxiety and less emotional control in the group of lower scholarship, as pointed out by McCandless, would tend to lower the level of functioning intelligence.

Popular Response (P).—The mean number of P responses was 8.1; standard deviation, 2.41. McCandless[9] reported exactly the same mean number of P responses for his high scholarship group. Other studies with superior groups either did not report their results for P, or gave their data in terms of P% and hence cannot be compared with the present findings. In Beck's group[23] of 157 normal subjects the ranges for P were found to be 0 to 4 (low), 5 to 9 (medium), and 10 or above (high). The mean number of P responses for this group was 6.79. Although the writers' group of medical students would still fall within the medium range, they had a significantly greater number of P responses than Beck's mean.*

Animal Content (A%).—The mean A% was 37.9 with a standard deviation of 10.0. These findings closely approximate those of Harriman,[10] Munz,[12] and Oeser[14] for their superior groups. Beck[6] reported a mean A% of 28 for his superior healthy adults. Other studies, such as those of Hunter[11] and Vernon,[13] reported mean A%'s for their superior groups which were higher and varied from 44 to 50. On the basis of the data derived from his 157 normal subjects Beck[23] determined the following ranges of A%; low (0-33.9), medium (34-59.9), and high (60 and above). The present group of medical students would fall within the lower limits of the medium range for A%. The mean A% for Beck's 157 normal subjects was 46.65 with a standard deviation of 13.12. The medical students thus had a significantly lower number of stereotyped per-

*Critical ratio = 3.98, significant beyond .001 level. However, the records of the medical students were scored before Beck's revision of his P response which was based on his 157 normal subjects. The mean number of responses for Beck's earlier control group (Ref. 6) was 5.92. The writers' study did not include the revised P responses. The critical ratio between this mean number of P for his group and the group of medical students was 5.41, significant beyond .001 level.

cepts.* This is to be expected in view of their very superior intelligence. The mean A% of 37.9 may appear somewhat high for the group, but the standard deviation of 10.0 would set the low range at about 28 and the high at 48. In comparison, the high range for Beck's normal group fell at about 60.

Interest in Anatomy Responses. (An).—Hertz (Ref. 24, p. 138)** observed medical students gave by far the largest number of anatomical terms." Harrower-Erickson and Steiner[24] discussed the distribution of anatomical responses in 108 medical students as compared with 116 non-medical students. These data were presented in tabular form (Ref. 24, p. 137, Table V).†

In the present study, out of a total of 3,300 responses given by the fourth-year medical students, only 261 were anatomical. These responses formed 7.94 per cent of the total productivity. As revealed by these data, not only did the present group show fewer anatomy responses than Harrower-Erickson and Steiner's group of medical students but also had only a slightly higher anatomy per cent than their group of non-medical students.

The mean percentage of anatomy responses for the group of fourth-year medical students was 8.2 with an SD of 5.25. The mean number of anatomy responses was 4.83; standard deviation, 3.47.

Harriman[10] found a mean of 3.54 anatomy responses in his group of college students, over 60 per cent of whom were taking

*Critical ratio between the mean A% of the two groups was 5.24, significant beyond .001 level.

**Study cited by M. R. Harrower-Erickson and M. F. Steiner (Ref. 24).

†In order to compare these data with those obtained in the present group of medical students, it was necessary to convert the data in Table V. The following method was utilized: The total productivity for each card of the total college group of 224 subjects was obtained from the data given for each of the 10 cards in Section VI (pp. 90-103). The total productivity for each card contributed by the 108 medical students of this total group was obtained from the same source (pp. 104-115). The actual number of anatomical responses given by the two groups was then obtained from the percentages given in Table V. This conversion yielded: (1) the total number of anatomical responses given by medical and non-medical student groups for each of the 10 cards, and (2) the percentage of anatomy responses of the total in each card, for both groups. Of the total 3,055 responses in the group of medical students, 13.8 per cent were anatomical. Of the total 2,751 responses in the non-medical group, 6.7 per cent were anatomical. These data would support Harrower-Erickson and Steiner's conclusion that "one sees a preponderance of anatomical answers in the records of medical students. It would seem clear that a familiarity with anatomical concepts and structures, and interest in anatomy courses which are taken during the year clearly leave their mark on responses given to the ink-blot" (p. 137).

courses in biology. In Beck's group of 157 normal subjects,[21] the mean number of anatomy responses was 1.55; standard deviation, 1.97. A chi-square test of significance afforded evidence that the frequencies of anatomical responses observed in Beck's group of normal subjects and in the present group of medical students differed significantly.* In a group of 60 neurotics Beck[21] found the mean number of anatomy responses to be 2.44; SD, 3.42. The chi-square test indicated also that the frequencies of anatomical responses between this group and the medical students differed significantly.**

These data indicate that there was a definite preponderance of anatomical interest content in the Rorschach records of medical students, even more so than in a neurotic group, wherein such interest content would be considered an index of anxiety. In medical students the higher percentage was attributed to vocational and training factors. Their anatomy responses were of a different quality than those appearing in neurotic records. In the latter case, vague anatomical charts stressing color, or responses determined by positional elements of the details were generally given. Anatomical responses given by medical students were described in technical terms and were less vague in their context.

It is interesting that the group of medical students in the Harrower-Erickson and Steiner study[24] gave a larger total percentage of anatomy responses than did the present group of fourth-year medical students. How many fourth-year students were included in their group was not reported. It may be that fourth-year students feel greater security than underclassmen and are better able to break away from their vocational training—therefore becoming less stereotyped in their interests. In any individual record, regardless of the subject's vocation, when the specialized interest of his vocation is emphasized in the interest-content to an extreme degree, it often indicates a defense against anxiety. This situation was aptly demonstrated in Beck's record of a physician[5, p. 333] in his reaction to anxiety precipitated by Card IV.

*The chi-square = 49.72 (four degrees of freedom); $P < .001$. Chi-square was used in preference to the usual critical ratio since anatomy responses do not form a normal distribution.

**Chi-square = 25.015 (four degrees of freedom); $P < .001$.

The Affective Sphere

Total Color Responses (ΣC).—The present findings as to high ΣC in this group of medical students were in agreement with those of other studies (Table 7).

Beck,[7] in his original monograph, indicated that the color total in superior adults was high. He considered a ΣC of 5 as high; the average being 3. Rorschach[29] found that intelligent normal subjects have 1-3 FC, 1-2 CF, and no C. This would set the limits of ΣC from 1.5 (FC=1, CF=1, and C=0) to 3.5 (FC=3, CF=2, and C=0). Those of average intelligence according to Rorschach, had a ΣC ranging from 0.5 (FC=1, CF=0, and C=0) to 2.5 (FC=3, CF=1 and C=0). His group of artists, listed under the heading of "Normals," had higher ΣC scores, ranging from 4.0 (FC=1, CF=2, and C=1) to 7.0 (FC=2, CF=3, and C=2) (Ref. 29, p. 51, Table VIII).

In his group of 39 very superior healthy adults Beck[4] found the average ΣC score to be 7.30. Beck also considered Rorschach's original numerical findings for affectivity in need of alteration, on the basis of subsequent studies. The trends Rorschach pointed out, however, have been confirmed.

Table 7. Color Responses for 60 Medical Students

	Mean	Standard deviation	Standard error of mean
Color total (ΣC)	5.80	5.25	0.66
Pure color (C)	1.08	1.73	0.22
Color form (CF)	2.42	2.88	0.37
Form color (FC)	3.57	2.90	0.38

Hunter's group of superior white adults[11] showed the same trend as to quantitative aspects of affective experiences as the present group of medical students. Her mean ΣC score for this group was 5.1. The mean ΣC of 4.7 for her group of superior Negro adults was only slightly below that of the whites. Munz[12] reported a mean ΣC score of 6.3 in his group of "male intellectuals."

On the other hand, studies by Harriman[10] and Vernon[13] reported lower mean ΣC scores for their groups of subjects. Harriman, who studied a group of 100 American college students, found a mean ΣC score of 2.68; standard deviation, 1.4. Vernon, in his study of Yale college students, reported a mean ΣC score of 2.5, while the mean ΣC score for his total college group was 4.0. Mc-

Candless,[9] in his study of officer candidates who were of superior intelligence and high in scholastic achievement, indicated a mean ΣC score of 3.5. His low scholarship group which was also of superior intelligence showed somewhat more affect, attaining a mean ΣC score of 4.5. However, the difference between the two groups was not a reliable one.

Roe,[13] in studying 18 paleontologists, found the group in general to be rather constricted so far as total affect was concerned. Of this total group, four were considered overproductive in their color responses while two were markedly underproductive. The nine technicians in the same field of paleontology followed approximately the same trend. The actual ΣC values were not given in this study. The generalization to be drawn, however, was that these superior normal adults, as a group, did not have relatively high total ΣC scores as most other studies with superior normal adults indicated. The general lack of affect was apparently part of the general pattern of inhibition she found in this particular professional group.

Pure Color Response (C).—The mean number of C responses was 1.08 (Table 7). Although Rorschach[10] considered "intelligent normals" as having, on the average, no pure color responses, findings of subsequent research have proved otherwise. However, in his group of artists, presumably one of superior individuals, Rorschach did report 1-2 C responses.

Munz[12] and Vernon[14] found mean C responses of 0.6 and 1.0 in their groups of male intellectuals and university students, respectively. Hunter's group of superior white and Negro adults[11] gave 0.5 and 0.8 mean C responses respectively. McCandless,[9] in his study of superior officer candidates, reported no statistical findings for pure color responses in this group, but remarked in a footnote that pure color responses in his group were too few to compute.

In Roe's group of paleontologists[13] not one of the 18 subjects had more than one C. No central tendency measure of C was reported, however.

In the present group of medical students, the range for C responses extended from 0 in 56.6 per cent to 8 in 1.6 per cent of the cases. Nine subjects (15 per cent) gave more than one C response.

Color Form Responses (CF).—The mean number of 2.42 CF responses (Table 7) is higher than that reported by the majority of other studies with superior groups. Hunter,[11] Munz,[12] and Mc-

Candless[9] reported lower mean CF responses ranging from 1.2 to 1.9. Vernon,[13] however, reported a mean number of 2.3 CF responses for his group of English university students. The present findings also compared well with Beck's superior adult group,[7] and those of Rorschach for his groups of artists and superior adults.[29]

Form Color Responses (FC).—The mean number of FC responses of 3.57 was higher than the findings in studies of Hunter[11] and Vernon.[13] The findings of McCandless[9] closely paralleled those of the present study. Beck[7] and Munz[12] reported larger mean numbers of FC responses for their superior groups. An upper range of 3 FC responses was reported by Rorschach[29] for his superior group.

Shading (Gray-Black) Shock.—Each of the 60 Rorschach protocols was examined individually, according to established criteria, for evidence of shading shock. Table 8 shows the frequency with which each criterion occurred in the 36 records in which some form of shading shock appeared. It will be noted that these criteria are among those discussed by Beck.[5] Criterion No. 8 in the table is additional and is in need of further experimental validation.*

The significant finding is that 60 per cent of this group of very superior adults show some form of shading shock. If we accept the psychologic trait denoted by shading shock, we must conclude that this group of subjects has a relatively low threshold for situations involving potency of threat, that is that there is a chronic preparedness to become upset. However, it will be noted from Table 8 that only six of the 36 subjects (16.6 per cent who show this gray-black shock, suffer sufficiently from the debilitating effects of anxiety to result in loss of intellectual control (increase in F— responses). This, of course, would distinguish the group from one in which anxiety was totally debilitating. Apparently the appearance of gray-black shock in this group must be regarded

*Essentially this criterion is identical with criteria No. 9 and No. 10, except that, in addition, there is an increase in productivity. It may be a more exacting measure of the cumulative effect of shading shock discussed by Beck (Ref. 5). This increase in productivity may represent a defense set up against the anxiety precipitated by the shading; a reaction formation which affords a magic form of undoing the anxiety. It is the authors' hypothesis that this defense against anxiety occurs primarily as a function of an obsessive-compulsive personality force. Of the six subjects who show this criterion, four also emphasized Dd in their approach. This may represent a defense against anxiety which is a function of displacement. The displacement to small detail may represent an actual substitution for the anxiety precipitated by the shading.

Table 8. Occurrence of Shading Shock Criteria in 36 Medical Students

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
1.				X						X
2.	X	X								
3.	X	X							X	
4.	X	X								X
5.	X	X								X
6.	X	X				X				X
7.	X						X			X
8.								X		X
9.	X	X								
10.		X				X				X
11.	X	X								
12.		X				X				
13.	X	X								
14.	X	X								
15.	X	X								
16.		X								
17.		X								
18.	X		X			X				
19.	X	X								
20.	X	X								
21.								X		
22.	X		X					X		
23.	X	X								
24.	X									X
25.		X							X	
26.	X									X
27.		X							X	X
28.	X		X					X		
29.			X	X				X		
30.		X								
31.	X	X			X					
32.		X	X							
33.		X	X							
34.	X									
35.	X									
36.	X						X		X	

(1) = First Response Time Retarded
(2) = R Noticeably Reduced
(3) = Increase in F— Responses
(4) = Verbalization of Displeasure
(5) = Description of Blot Details
(6) = Increase in A%
(7) = Increase in Hd Responses
(8) = R Increases Noticeably with Many Shading Responses
(9) = Dd Responses Increase, but without Increase in R
(10) = Shading Responses Increase, but without Increase in R

within the same frame of reference so aptly described by Beck[5] in his discussion of color shock:

"The shock reaction is found throughout all groups of normals —children, adolescents, adults of all intelligence levels—and it may be of any degree. Thus it demonstrates the old cliche that we are all, in this high pressure age, neurotic. But the degree in which it occurs is an index of whether the adjustment pattern is referable merely to the neurosis characterizing this era, or bespeaks the real thing, i. e., 'sick' neuroses [Ref. 5, p. 39]."

Color Shock.—Thirty-three (55.0 per cent of the total group show some degree of color shock. (See Table 9.) In 12 (36.3 per cent) of those experiencing color shock, the reaction was severe enough to cause a breakdown in intellectual control (increase in F— responses). The criteria employed to measure color shock are among those discussed by Beck.[5]

Only 15 (25.0 per cent) of the total group give no evidence of either color or shading shock. Twenty-six (43.3 per cent) show both color and shading shock. Nine (15.0 per cent) evidence color shock alone; 10 (16.6 per cent) have only shading shock.

It is of special interest to note that, although the occurrence of shading and color shock was so frequent in this group, not one of the gray-black or color cards was rejected.

Roe[18, 19] also found a surprisingly high incidence of both shading and color shock in her Rorschach studies of subjects in various scientific professions. In group Rorschachs of 188 biologists she reported, "a very high incidence of shading and color shock,"[19, p. 43] and in her group of 18 paleontologists, shading shock occurred in 50 per cent of the cases. Color shock was more frequent and was found in 15 of the 18 subjects, with eight of these exhibiting more than mild shock.

Shading Responses.—Table 10 shows the means of the various combinations of shading responses. The scoring of these responses follows the criteria stipulated by Beck.[5] In his group of 157 normal subjects Beck[20] found significantly less emphasis than is found here placed upon the shading elements, mean number of FY re-

*Chi-square = 129.44 (five degrees of freedom); $P < .001$.

Table 9. Occurrence of Color Shock Criteria in 33 Medical Students

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
	First response time retarded	R noticeably reduced	Increase in F— responses	Description of blot details	Increase in Dd responses	Increase in Hd responses	Increase in A%	Regressive shift in color resp. FC→FC— CF→CF— CF→C
1.			X					
2.	X				X			
3.	X	X	X					
4.					X			
5.	X		X					
6.			X					
7.	X	X	X					
8.	X				X			
9.	X						X	
10.	X							
11.	X		X					
12.	X	X						
13.		X						
14.	X	X			X			
15.	X							
16.	X	X						
17.		X						
18.	X						X	
19.	X		X					X
20.	X			X				
21.	X		X					
22.	X		X					
23.	X							
24.					X			X
25.	X	X				X		
26.	X				X			X
27.	X	X						
28.	X							X
29.	X		X					
30.	X				X			
31.	X	X						
32.	X		X					
33.	X							

sponses: 1.38, SD: 1.61. Compared with 85 per cent of the medical students, only 8.2 per cent of Beck's group has more than four FY responses. That the frequency of FY responses differs greatly

between the two groups was indicated by the chi-square test of significance.*

Table 10. Shading Responses of Medical Students

	Mean	Standard deviation	Standard error of men
FY	6.57	3.20	.413
YF+FY	7.63	3.58	.462
Sum of all responses with Y (Y, YF, FY, CY, CFY, FCY)*	8.80	2.29	.295
FV	1.88	1.73	.223
VF+FV	2.15	2.07	.269
Sum of all responses with V (V, VF, FV, CV, CFV, FCV)	2.52	2.19	.284

Also, a significantly larger number of FV responses than for Beck's 158 normal subjects[28] occurs in the medical student group. The mean number of FV responses for Beck's normal subjects was 1.03 with an SD of 1.67. A chi-square test of significance showed the extent to which the distribution of FV responses differ in the two groups.** Twenty per cent of the medical students have four or more FV responses as compared with 4 per cent of Beck's normal subjects.

There is an insufficient number of studies on shading responses with superior groups in the literature which follows Beck's scoring to afford any extensive comparison with the results obtained in the present study. McCandless[9] found his high scholarship group to have a mean of 1.9 "vista R's" which would compare favorably with the findings on these medical students.

As to the psychologic force represented in shading responses, a number of questions still need to be answered through actual experimental validation. It is not within the scope of this paper to consider the involved academic discussions in reference to shading responses which have already been raised by others.[32, 33]

The factor of interest here is that this superior group of fourth-year medical students gave a significantly greater number of shading responses than did a group of 157 normal subjects. The ques-

*In view of the skewed distribution, the mean for ungrouped data was calculated for pure Y responses, and for all color responses containing Y as a blend. Mean Y responses = .316; mean Y blended with color responses = .95; mean V blended with color responses = .45.

**Chi-square = 22.50 (three degrees of freedom); $P < .001$.

tion to be asked is one involving the relation of these findings to the total personality structure, as revealed by the other Rorschach variables. The answer to this question must be formulated in terms of the experience which is expressed in V and Y responses. Beck considers both as representing "affect as dysphoria."[5, p. 34] The Y responses indicate a passive reaction, or, as Beck expresses it: "an absence of activity which can go all the way to passivity."[5, p. 35] Inferiority consciousness is attributed to the V responses and an "unpleasant, morose feeling tone, depressing in effect, always overlies the experience expressed in V."[5, p. 34]

The blendings of V and Y with color responses are not unusual or infrequent for superior groups; these reflect the ability to experience situations intensely and vividly, and result from the complex structure of a rich personality. In unhealthy individuals the same blends may be a measure of the conflicts which are being experienced. As to the excessive number of FY, if one accepts the view that they reveal passivity, one must conclude that this was an exaggerated trait for the present group. Of the 60 per cent of the cases showing shading shock, 36 per cent met the anxiety situation by reacting with an increase in responses involving shading.

Until individual analysis of each record is conducted, it seems advisable to hold in abeyance conclusions as to what the excessive use of shading implies in this group. If it does indicate passivity and, to some extent, inferiority consciousness, occurring with such frequency as is found in the present group, is it part of a personality dynamism in the complex psychic potential of superior persons? The effect it has in this group does not need to be debilitating as it may be in the actual "sick" neuroses. It may incite effort toward achievement and arouse determination without deleterious effect to the ego. These traits are present in this group, as seen in the high level productivity, organizational activity, broad interest content, and white space responses.

Fantasy Responses (M).—The mean number of M responses was 7.5; SD: 7.46. Beck[5] reported a mean number of 8.1 M responses for his superior group. Oeser's group of English college men and women[14] gave a mean number of 8.7. Rorschach[20] gave no actual mean values for M but indicated that five or more M occurred in his group of superior adults and artists. In the group of male intellectuals examined by Munz,[12] the mean number of M responses was 6.2. Other studies with superior groups reported

lower mean numbers of M. Harriman[10] and Vernon[13] reported means of 4.3 for both their groups of college students. Hunter's group of white and Negro adults[11] had mean M responses of 3.5 and 1.7, respectively.

Roe[19] reported a mean of only 3.07 M responses for her group of biologists. However, this datum was based on her entire group of 188 biologists, who ranged in age from 20 to 79 years. An important finding noted by Roe was that M responses tended to decrease with increase in age, the mean number of M being significantly greater in the younger age groups. It is necessary to consider the fact, when Roe's group is employed for comparison, that the average age in the present study of fourth-year medical students was 23 years, nine months. Roe[18] found her group of paleontologists also to be "extraordinarily deficient in M responses."[18, p. 322] No measure of central tendency was given, but the inhibition of creative imagination in this group was emphasized.

Experience Balance (Exp.).—The quantitative balance between M and ΣC was determined for each of the 60 subjects. In describing the degree to which these components outbalance one another, the criteria formulated by Beck[7] were used. Thus the following method established the degrees of introversiveness or extratensiveness present:

a. Introversiveness:
   1. Marked: Number of M responses three or more greater than ΣC.
   2. Moderate: Number of M responses less than three greater than C total.

b. Extratensiveness:
   1. Marked: ΣC three or more greater than total number of M responses.
   2. Moderate: ΣC less than three greater than total number of M responses.

c. Ambiequal: ΣC and number of M responses equal or approximately equal.

On the basis of the data given in Table 11, the outstanding experience balance types were ambiequal and introversive. Half the total group shows an introversive experience balance. The introversion was marked in 41.6 per cent of the total group. The other

subjects divide themselves equally between the extratensive and ambiequal types. The occurrence of ambiequal experience types in 25 per cent of this group of medical students raises the question of probable obsessive-compulsive features appearing in their personality structures. Reference has already been made to the fact that the Dd mode of approach is prevalent in the group. Before any conclusions may be drawn from this study as to the frequency of obsessive-compulsive patterns, other Rorschach variables in relation to the total personality structure would have to be considered, and an analysis of individual protocols undertaken.

Table 11. Types of Experience Balance in Medical Students

	M>C Marked introversion	C>M Marked extra-tensiveness	M>C Mild introversion	C>M Mild extra-tensiveness	M=C Approximately ambiequal
N	25	10	5	5	15
%	41.6	16.6	8.33	8.33	25.0

White Space Responses (S).—The mean number of white space responses for the group of fourth-year medical students was 5.22; SD: 2.41. Beck's 157 normal subjects[28] showed a significantly lower mean number of S responses (1.99). The chi-square test of significance proved that the frequency of white space in the two groups differed significantly.*

Beck[5] stated that in most healthy individuals an average minimum number of two to four white space responses occurred. It would appear that the present group of medical students gave, on the average, more S responses than would be expected. All other studies of superior groups cited throughout this paper reported much lower mean S responses ranging from 0.7 to 1.7. Differences in scoring may account for this lower range. Considering the high levels of R, F+, Z, ΣC, the white space percept in this group would tend to indicate the reinforcement of a strong ego by determination and self-will. This would be an asset to the personality in affording persistence in achievement. It is of interest that of the four superior records given as examples by Beck,[5] three have high S scores of 11, 6, and 10. In his earlier monograph[7] a mean S score of 4.7 was reported for the four adults of superior intelligence given as examples. In this same monograph, Beck listed S

*Chi-square = 39.95 (three degrees of freedom); $P < .001$.

responses as occurring in a relatively high quantity in adults of superior intelligence.

Roe[18] did not find an emphasis on S responses in any one of her group of 18 paleontologists. In her group of biologists 14.7 per cent were regarded as having an excess of S responses.*

Discussion

This study presents the Rorschach findings of 60 fourth-year medical students. The results of this investigation are of particular interest because they afford an opportunity to study the personality structures not only of a group of very superior individuals but also of a selected professional group, one being trained in medicine.

The scope of the present study is limited primarily to the presentation of a statistical analysis of the various Rorschach variables which appear in the group. Other studies of superior groups are reviewed, and their findings are compared with those of the present study. In making such comparisons, it should be emphasized that several variables must be considered. Statistics such as those of Roe[18, 19] and Harrower-Erickson and Steiner[24] are, for example, based on Rorschach records obtained by the group method. Although in all the studies reported superior groups have been used, populations of the groups are diverse. In comparing the findings of this group of medical students with other superior groups, the additional factor of specialized training in medicine has to be considered.

Regarding the present group solely from the point of view of its superior intelligence, the findings obtained compare well with those which are considered characteristic of a superior group of adults. In the intellectual sphere the high level of productivity, the large amount of intellectual drive and organizational energy, the superior level of form accuracy, and the originality of interest-content with a minimum of stereotypy are all apparent. Affectively there is a rich source of energy which can be drawn upon and utilized in adjustment. In fantasy life, there is an imaginative talent which, in view of the personality structure as a whole, makes creativity possible.

*See second footnote, p. 755. The data for S responses were obtained by the method noted there.

In addition to these findings there are those which, on the basis of results with other superior groups, must be considered unique for these particular subjects:

A. In the affective sphere the frequency of both shading and color shock has been noted. Although this reaction is not herein accompanied by any debilitating effects, as it is in the actual "sick" neuroses, the fact remains that it represents a lowered threshold for becoming upset and reacting to the potency of threats from the environment. The explanation has been offered that this is not only the result of a cultural factor characterizing the high-pressure era in which we live, but for this group, it may be even further emphasized by other threatening factors. The competitive situation in which the students find themselves, passing medical school as well as state board examinations, may add to the general pressure upon such a group.

Rather than endeavor to explain on the basis of passivity and inadequacy the frequent appearance of shading responses in this group, the authors prefer to hold such a conclusion in abeyance. Of all Rorschach variables, the shading responses are most in need of further experimental exploration. These shading responses may very well be an integral part of the personality structure of superior individuals, without any deleterious effect upon the ego. Whether they have a specific significance for this group of medical students, revealing some characteristic personality force, can be ascertained only by comparing their frequency in other superior groups. Beck[7] has already noted the tendency toward frequent FY responses in superior individuals (Ref. 7, p. 10).* Similar findings may be present in other professional groups, as in the biologists studied by Roe[10] in whom there was a high frequency of both shading and color shock. However, Prados[17] does not find any excessive use of shading in his group of artists, even though it might be expected that art training would increase one's sensitivity to shading differentials. Until further investigation of these shading responses is made it appears unwise to assign a pathognomonic interpretation to them. It may very well be that in the normal superior adult they reflect a healthy self-evaluation and determination, inciting effort toward achievement.

B. In the intellectual sphere the interpretation of the emphasis upon Dd in the mode of approach is dependent upon a considera-

*The quantity for FY responses in superior adults is listed as "high."

tion of the total personality structure. Until analyses of individual records are made and clinical case material is available, it is not possible to determine whether or not this emphasis upon the rare details is representative of obsessive-compulsive behavior in this group of medical students. In the compulsive neurotic, we are accustomed to interpret this emphasis as indicative of the internal pressure which causes the individual to attend to, and mull over, the picayune aspects of the environment. In schizophrenics, the same emphasis upon rare details reflects attention that lacks direction. In normal subjects, however, the excessive attention to rare details does not necessarily represent a pathological factor. Beck considers the possibility of an emphasis on rare details in normal subjects as a "mark of a good observer."[25, p. 14] However, Beck qualifies this statement by stating that the examiner "would be well advised to use the finding also as a lead to the presence of compulsive phenomena."[25, p. 14]

In explaining the emphasis upon rare detail in this group of medical students, several contributory factors may be present. Medical education itself may result in the development of intense observation. If we consider the possibility of the Dd emphasis as bespeaking the presence of obsessive-compulsive phenomena, then we have to ask how debilitating an effect this has upon the efficiency of the total functioning personality, especially within the intellectual sphere. If we consider the fact that in this group of medical students intellectual drive, productivity, and creativity are not interfered with, it would appear that the effect of such obsessive-compulsive phenomena is not a debilitating one. In our culture, where there is a great premium set upon achievement, one may very well ask whether such behavior may not even enhance rather than impede achievement.

C. In reference to the experience balance, the large number of cases in which introversion is present need not be interpreted as unhealthy. Introversion may be constructive if the respect for reality is maintained as it is in this group.

Conclusions

1. The individual Rorschach scores of 60 fourth-year medical students were statistically analyzed and compared with those of various groups of superior adults reported by other investigators.

2. In the intellectual sphere the 60 medical students were sim-

ilar to other superior adults in productivity, intellectual drive and organizational energy, form accuracy and originality of interest content; they differed from other superior adults in the emphasis upon Dd (rare detail) in the mode of approach.

3. In the affective sphere these medical students resembled other superior adults in richness of sources of energy available for adjustment. They were unusual in the frequency with which both shading and color shock were noted.

4. The experience balance of the medical students showed half of the total group to be introversive, while a quarter were extratensive and a quarter were approximately ambiequal.

5. The mean number of white space responses given by the medical students was significantly higher than in other groups.

6. The significance of various Rorschach variables in the total personality structure of medical students is discussed.

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THE INVOLUTIONAL DEATH REACTION

BY POMPEO S. MILICI, M. D.

Much has been written concerning the etiological role of the alteration of endocrine physiology and of the psychology of advancing age in the development of the involutional-melancholic psychosis. But changes in the body chemistry and the psychology of declining years are not to be regarded as the distinctive, peculiar features of those who go on to melancholia. They are to be found just as readily in the normal course of life where they may succeed only in bringing on ever so faint a coloring of depression.

It is when the rather clear-cut pre-involutional melancholic personality make-up reacts to internal dissatisfactions and to external problems in a pathologically-regressive manner that we speak of disease. The reaction then varies from the mildest of melancholia to the most severe, and, as it deepens, the depressive mechanisms come increasingly to the fore. The description which follows, in order to contain the complete psychological structure, necessarily pertains to the full-blown reaction.

Confronted with life's problems, for him oversevere, the person who becomes a melancholiac shows signs of increasing dissatisfaction and distress. There is a growing moroseness, an increasing introversion of affect and of thinking, with consequent constriction of normal interests and of contacts, and disturbance of orderly, logical thinking.

With sufficiently-deepened introversion, there is loss of feeling, apathy for external and internal impressions. The disturbance of orderly thinking, which naturally also increases as the introversion deepens, is manifested by difficulty in concentration and comprehension, in absentmindedness and in forgetfulness. There are complaints that the head "does not work right," that the mind is blurred, confused, is becoming "dumber and dumber," is stupid, empty, paralyzed.

In depressive introversion, exaggeratedly concerned with the self, there is a brooding over difficulties and worries, many of them trifling but growing to mountainous proportions as attention is increasingly fixed upon them.

The past life is painstakingly and autocritically reviewed. One dwells upon his mistakes, may bring up adequate cause for depres-

sion but often grossly exaggerates trivial misbehavior; and there may be considerable retrospective falsification and rationalization —and an absorption with the might-have-beens. "I am worried about everything. I can't stop thinking of all my life. If only I could start all over again."

With increasing depression, such a person is increasingly remorseful, self-deprecatory and self-accusatory. There is a sense of unworthiness, of uncleanliness and of wickedness. He considers himself a burden to all. He condemns himself for being "no good," "very bad," "useless," "rotten," and "worthless." He is dirty, filthy, and he smells bad. He has lost his will power, has done wrong, has spoiled his life, should have done differently. He is not a fit associate, the environment is too good for him. He is unfit to attend church, he has been false to God. "I am filled with feelings of unworthiness. I lived in sin. Oh my God, I have done wrong. I have been wicked all my life. Oh, please take my word for it. I was always so false. I have accomplished nothing worthwhile. I am a discredit to my religion. I am not deserving of health. Oh, if you only knew how dreadful I am and how bad. I am the scum of the earth. I am not fit to live. I ought to be out of the way, I ought to be in the ground. I ought to be down at the bottom of the ocean. I want to be put in the garbage can. I hate myself."

In a state of anxious dread, there is a depressive and paranoid expression of impending disaster. There is worry over advancing age, talk of becoming mentally ill and having to be certified, a fear that the family will be ruined financially, left without support, disgraced and in suicidal mood. He is to be terribly prosecuted and punished for crimes. Fearful of prison, he talks of arrest. Others watch, follow and talk about him. Footsteps are heard. Everyone is trying to take his belongings, to put him out of the way. He speaks of having been cursed, punished and forsaken by God. His soul is damned and lost. He is going to die, to be tortured and killed in a horrible manner. Condemned to everlasting torture, he is going to purgatory, to hell, and he will never get to Heaven. "I am lost. I must die. I know that I cannot be saved from a terrible death. God put His finger on me." The environment also is to be subjected to varying stages of annihilation.

The interest withdrawn from the environment is in varying degrees centered upon the body. There are complaints of all sorts of

bodily weaknesses, pains and paresthesias. There is talk of headaches and dizziness, of pressure on the head and tension in the neck. There are noises and poundings, cracking sensations; the head is about to burst. There is a drawing feeling in the eyes; the tear ducts, the nose and mouth are dried up, the throat is contracted; it is difficult to speak, to swallow or to breathe. The body, in part or in its entirety, is "limp," "numb," "taut." There is pain in the spine, tightness in the chest, a substernal fullness and smothering. The heart jumps, pounds and palpitates. There is electrical sensation, a pressure, pinching and pricking, a "shivering" inside and a trembling all over, an intense sexual feeling which remains unsatisfied, an inability to relax. The complaints, neurotic in type at first, develop into delusions of disease and of bodily change.

In such an introverted state everything is too much for him, the sufferer, everything is annoying. "I am ready to jump out of my skin." It is increasingly difficult to attend to the usual routine, and there is deterioration in self-care, with neglect of home, of social activities, and of employment. The person wants to be quiet, to be left alone. He goes on lonely walks. There is a silent sitting about, a refusal to get up in the morning.

Hostility comes increasingly to the surface. There is heightened intolerance with rejection of the family and of others and there are obsessive and compulsive feelings, thoughts and actions of a sacrilegious, profane and violent nature. "Sometimes awful thoughts come to my mind and I do not put them there. Oh, they are terrible thoughts, one right after the other. Oh, those horrible thoughts and I try to wipe them away and they won't go. I curse everybody. I curse the Lord. I would kill anybody sitting next me. I hate everybody and everybody hates me. Perhaps there is too much bitterness in my heart. Oh God, forgive me."

Increasingly vivid as the depressive introversion increases, is a feeling of unreality. In the autopsychic sphere there is depersonalization, the "I am not I." "I am changed. I feel strange and unnatural." There is complaint of a loss of feeling, of being in a daze, of going about in a "dream" like an "automaton," and of body changes. "My body feels as if it does not belong to me. It is like a piece of wood, of lead, of glass, a living stone."

In the allopsychic sphere, everything may seem changed, strange and unreal. The sufferer speaks of "fogs," "mists," "veils,"

"masks." He complains of dimness of vision, and fears blindness. Things are seen as if from a distance. Objects appear distorted in size, shape and color, seem to move about, to talk and to make signs. Sounds seem to come from afar and are strange to his ears. Persons change weirdly under scrutiny, appear to be acting, seem to be monkeys, machines, automatons, devils. Relatives appear changed and disguised, are looked upon as substitutes, as complete strangers. "He is only a person with a mask on to look like him. He is not my son—it is only his image." Vegetation appears to be off-color and artificial. "Everything has been changed. Nothing seems the same. I can't distinguish what is real and what is not. Everything is topsy-turvy, all twisted up."

With sufficiently-pronounced unreality, there are delusions of negation, with denial of personal attributes, belongings and relationships, of a soul, of external and internal organs and organ functionings, of the body and of the external situations.

The withdrawal from reality, the depressive hostility, with its delusions of disease, poverty, unreality, negation and death, are closely allied exhibitions of the death motif.

There is expression of desire for, and supplication for, release through death, a begging to be killed in myriad manners, to be given access to self-destruction. "I want to die. I wish to God I could die. I wish my heart would stop. I want to jump in the water. I want to be buried. I am done eating. The only merciful thing you can do is to dig a hole so I can have some peace."

At deeper levels, there are delusions of dying or of being already actually dead. There is an obstruction of the bowels; everything is closed; the internal organs are burning up; something is breaking up inside; the heart has stopped; everything is shrinking, rotting, dried up, shriveled up and dead. "My body is not a functioning body. It has stopped working and is dead while I am still alive—I feel I am going to die today or tomorrow. Dead souls enter my body. Pretty soon I am going away. I am dying—I feel I am not alive. It is thrown at me all the time that this is a cemetery. I am in a graveyard. Life has left me. I feel dead. I am not alive. I am dead. I have to go out and lie down now. They didn't bury me—I stopped breathing. I gradually couldn't think. I kept getting worse and worse, and then I just lay and lay and I died. I just went to sleep. I just tried to live in a coma. Now I am nothing but a spirit."

Finally the entire family, the neighborhood, the world, is dying or dead. Relatives and others appear to be shriveling up, withering away. The home has been destroyed. No newspapers are published, there are no longer any business transactions, no more employment will be available, there is no money. The trains and the buses have stopped running, all the lights have gone out, all the power in the world has been turned off. The sun has lost its splendor. The normal course of heavenly bodies is altered, the sky is falling, oceans are disappearing, there are changes in the weather, time relationship is confused. Plant life is dying, agriculture has stopped, there is no food. People have stopped eating and sleeping, few are living in the world, all have starved, all have burned, everyone is gone, everyone is dead, there is no life, there will be no more babies, all are spirits, the end of the world has come, all is clay. God is gone.

The sufferer holds himself responsible for all this, feels that he is to blame for everything. He has infected, disgraced and harmed his family, has driven his loved ones "insane" and to their deaths. Innocent persons are punished and suffer on his account. He is a devil and puts curses on people by looking at them. He makes people ill, causes epidemics, widespread catastrophic destruction and death, all the troubles in the world. "I am the cause of all the ills of the world, for the death of trees and babies, for changes in the weather. You don't know what I have done. I am wicked. I barren things, the grass and the birds. I corrode the pipes. Nothing will ever grow about here. I disgrace the world. I am a murderer. I kill everyone. I have caused everything to be dried up. The next generation will have nothing. I have put the whole world out of existence. I have killed the whole world. It is awful to be the cause of so much trouble, heartache and desolation."

Hallucinations correspond with the depressive and hostile themes. Voices warn, command and control, accuse one of, and condemn him for, all sorts of things, call him all sorts of names and threaten dire consequences for him, for his family and for others. They threaten and promise death and seek suicide; they tell him not to eat, to kill himself and his family. Dead relatives and others ask to be joined in death. He hears the preparation for his torture, the sounds of other killings, the lamenting, screaming,

cursing entreaties of the tortured, the death rattles and the tolling of bells.

Visions depict the scenes of suffering, the preparations for death and the actual horrible killing. There are visions of the supernatural and of general destruction and death, of persons going to, or being forced to, their deaths, of crashes of all sorts, of buildings being razed, of forest fires, of burials at sea and boats sailing away, of action on battlefields, of shrouds, coffins, morgues, graves and cemeteries, of dead relatives and others as spirits, corpses and skeletons.

In accordance with the affective pressure and level of regression, there are inhibited reactions, or excitations with pressure of thought, tenseness and restlessness, depressive lamentations, gestures of despair, implorations to all, along with resistive, disturbed behavior, impulses to scream, hostile activity toward others, destruction of valuables, self-mutilation and suicidal attempts.

"Life is too hard for me, too much trouble. Things are in an awful mess. Everything has gone wrong. Everything that I have built up has tumbled down. The world is all changed for me. It all seems to hit a discordant note. I feel like crying all the time. Oh my God, Oh my God, it is terrible. The future looks too dark. I can't see my way clear. I can't go on any further. Everything has come to a standstill. I can't stand it. I feel overpowered. I can't hold myself together. I have lost control of myself. I am falling apart. I have lost all ambition, all my confidence. I have no interest and can't care. Nothing makes me happy. I can't laugh and I can't cry. I feel there is no life, no desire, no feeling. There is nothing left of me. I feel just like nothing at all. Nothing can be done for me. I can never get better. I shall never be happy again. I feel just perfectly awful. People can't imagine how dreadful I feel. I suffer the torments of hell. There is no use trying to make anything out of life anymore. Everything is futile. There is no more hope. It is all over. I am uprooted. I am doomed. What is the good of living? I have nothing to live for. Nothing is worth while. I am tired of living. I have got enough of this world. If only I could run away from everything. I don't want to see, or hear or speak. I want to stay in bed and close my eyes and forget everything. I wish I could go to sleep and never wake up. Death would be better than a living death. I

would be better off dead. I don't want to live anymore. I want to die. I am dying. I am dead. Everything is dead."

Such is the driving psychology of the involutional depression. Battered by life, the person both withdraws, and is forced, into a depressive introversion, into the protective and annihilating death reaction.

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THE ANXIETY SYNDROME IN ALCOHOLISM*

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The Psychologic Basis

In the course of the treatment of chronic alcoholism, special studies have been carried out to determine whether some common basis for heavy drinking could be found. The symptoms observed in 38 cases previously studied were carefully reviewed. The most common symptoms noted in these cases were: (1) "nervousness" and restlessness; (2) depression; (3) feeling of weakness and apathy; (4) "funny feeling" in the abdomen associated with fullness in throat at times; (5) insomnia; (6) tachycardia; (7) inability to concentrate and pressure in the head at times; later a (8) "compelling" feeling requiring one to drink.

These symptoms were characteristic of the anxiety syndrome and were considered significant. Similar significance was attached to the history given by a patient with an education at the college level who experienced a sudden onset of symptoms consisting of pressure feelings in his head, rapid heart, nervousness and "sensation of dying" and need for fresh air—which were relieved by whiskey. This treatment given to him by a friend was the same that was recommended to his friend when he, himself, had suffered similarly a few years before. Thereafter, this patient used alcohol only when these attacks occurred, or when he was upset or worried. He sought treatment when he found he had to rely very much on alcohol.

These observations from the review of past cases, along with data obtained from the history of this patient, caused the writer thereafter to question all patients to determine their reasons for drinking. The more common replies received were:

(1) The boys I went around with drank a lot, so I got into the habit. (2) It's given rather freely wherever I go, and easier to get than a sandwich. (3) I work around the stuff all the time, or around people who have access to it. (4) Just a bad habit I slipped into. (5) I am from a nervous family and drinking helps my nerves. (6) My job. (7) My family (nagging wife or parents). (8) Bad business deals and financial reverses. (9) Lonesomeness—not really understood by others. (10) Sensitive feelings. (11)

*Study made with funds from I. J. Kaufman Research Fund.

As a child my family gave it to me, or I stole it. (12) I get so nervous at times, that I must get it to straighten out. (13) I am rather shy around girls and get more courage when I drink.

When it was pointed out to these patients that others, similarly exposed and with similar experience, did not become alcoholics, they readily saw that these reasons in themselves were not enough, but they were unable to provide additional causes for the drinking habit. For the most part they had little idea about the "why" of their drinking. Their introduction to alcohol was chiefly by the following ways—parties (social drinking), occupation, friends, illness, auto-suggestion, or curiosity.

The type of feeling they noted in themselves prior to drinking, and the age factor were next carefully investigated. In 67 cases studied the ages of onset of their drinking were as follows:

Table 1

Age	No.	Age	No.	Age	No.	Age	No.
5	1	12	3	20	6	25	1
7	1	13	2	21	6	28	1
9	1	14—15	6	22	4	33	1
11	1	16	13	24	3		
		18—19	17				
	4		41		19		3

The onset of drinking was notably heaviest at the age of puberty or shortly thereafter.

In nine cases, early drinking resulted from being around parents or relatives who drank, and who gave their youngsters whiskey as "toddy." The drinking habit, however, was not in any way different in these from those who started their drinking later.

The symptoms noted in these cases at the age of puberty and thereafter, as well as in the other patients who started their drinking later, were in the order of frequency, as follows:

(1) Restlessness and shaky feeling; (2) nervousness and generalized weakness with no ambition and no "pep" (lassitude); (3) inability to concentrate; (4) insomnia; (5) gastro-intestinal upset (choking, gas, or "butterflies" in abdomen); (6) rapid heart; (7) poor memory (recall not so good); (8) pressure feeling or tightness in the head and down the neck; (9) unexplained fearful feeling with feeling of doom at times, or "scary" feeling.

These symptoms were observed to be associated at the onset with sexual frustration. The appearance of such symptoms was considered sufficient justification for a drink to "calm the nerves." The patients noted, however, that it took more and more alcohol to "calm their nerves," so that at times drinking lasted several days.

It was observed that eventually they associated every unpleasant situation they had to face, or the anticipation of one with the need for a drink and later blamed these situations for their drinking. Most significant was the fact that these patients found in alcohol a gratification for their sexual urges, and later it became a substitute for sexual congress. In many instances where the symptoms existed, marital relationship became markedly disturbed, and ended in separation or divorce.

It was also noted that at the beginning of drinking there was increase in sex desire, but eventually there was indifference and loss of desire. As the frequency of bouts increased, sexual desire gradually decreased. These factors were considered of tremenous import in trying to reach the basic drive in drinking.

A further study of these cases revealed that:

(1) Following separation from their wives, about 30 per cent of the subjects returned home to their mothers. (2) Another 50 per cent admitted greater preference for their parents than mates, as the belief was that the parents (chiefly mother) were more sympathetic. (3) Another 20 per cent had no preference. (4) Tremendous compensation by the drinking husband (or wife) was noted in every instance after the drinking was over. He (or she) was more affectionate and considerate than ever, and his (or her) pledges and promises became more numerous after each attack subsided and were associated at early stages with a strong sense of guilt. In every instance, the non-drinking wives or husband felt greatly attached to their drinking partners in the non-drinking intervals because of the unusual attentiveness shown and the feeling that he or she was exceptional. Eventually, as the non-drinking intervals became shorter, most of them became disillusioned, and separations ensued.

In all of the cases where heavy drinking began after puberty, there was an unsatisfactory sexual adjustment or ignorance of sex urges, prior to the drinking habit. On the other hand, even where the adjustment was satisfactory, once alcohol had previously been

imbibed to relieve emotional tension or other nervous upsets prior to marriage, alcohol was again utilized to help in the relief of these situations regardless of sexual adjustments at marriage. This confused and distorted the subject's thinking and accounted for the feeling that alcohol was taken by him to counteract certain situations, whereas the difficulty was inherent in himself. This was all the more true since in every instance, save the nine cases already cited, the drinking came first, to some degree, and problems that allegedly started this drinking occurred afterward.

In the patients in whom drinking began before puberty, there was an unsatisfactory sexual adjustment after puberty. In both groups, the sexual desire became manifested in symptoms of anxiety, which responded to alcohol. These patients were unaware of such a relationship and in many instances were startled as they reviewed their own past. One patient was known to remark, "My husband is a bottle of whiskey." When the patient became aware of and sought a correction for his (or her) sexual maladjustment, a basis for the satisfactory treatment of the alcohol addiction was also established.

Comment

In the study of 67 alcoholics, and a review of 38 cases previously studied, it was noted that, even in the cases where drinking started in childhood, the nervous tension with symptomatology of the anxiety syndrome observed at and after puberty, appeared to serve as the basis for the persistent use of alcohol. Why more individuals do not drink to satisfy their anxiety which would seem to be greatest at puberty is a problem that needs further study. It is the opinion of Schilder[1] that alcoholics experience definite feelings of sexual inferiority. Banay[2] has suggested that alcohol may become a substitute for sex gratification, and points to a psychosexual problem in alcoholics. Moore[3] has noted that alcohol is used to relieve the nervous tension of drinkers, that this drinking usually started while young, that inadequate preparation for, or information about, sex was a factor for pertinent consideration. Karpman,[4] too, has considered the alcoholic very definitely as a neurotic, while Kraines[5] attributes addiction to a determined internal drive. The findings of these authors are parallel with many of the present observations. The studies by Stevenson[6] into the causes given by patients for their drinking revealed, as did the

present one, that they have no deep insight into their basic cause for drinking.

The return of alcoholics to the mother or mother-substitute following separation or divorce on the part of the male; or the return of the female to the father is one point which needs further study. The frequent findings of equal regard for wife and mother, with a leaning slightly toward the mother, is a pertinent observation.

Norberry[7] has noted the strong filial over-dependence in his cases, while parental training and attitude would seem pertinent to Schilder.[8] In this respect, Knight[9] has noted that most alcoholics have been married and divorced at least once, so that adjustment to marriage constituted a problem to them. Moore[10] has described an attachment of males to their mothers greater than the average, noting some infantile and immature patterns of behavior as well, all of which were observed in this study. All in all, it showed that marriage as a way of life was not fully accepted by the alcoholics studied.

Strecker[11] has noted that the alcoholic is preponderantly an introvert. This, the present writer believes, is definitely associated with psychosexual behavior and, hence, creates part of the difficulty in making a satisfactory proper heterosexual adjustment.

The wish to escape reality, as noted by Peabody[12] should be carefully evaluated, since the incidence has been noted as being originally psychosexual and later extending to all difficulties encountered. Moore[13] has observed the need of alcohol to sublimate the emotions in the alcoholic.

While the cases studied were too few from which to draw definite conclusions, certain trends were noted:

(1) The symptoms that seemingly provoked alcoholism or caused its persistent use were those of the anxiety syndrome and occurred mostly at puberty. (2) Alcohol was found capable of relieving such symptoms but gradually increasing amounts were necessary. (3) Whenever an emotional upset or problem arose thereafter, alcohol was tried as the best means of relieving the unpleasant feeling or situation, and eventually the condition was blamed for alcoholism—hence the many reasons given for it. (4) Alcoholics seem to remain with their marital partners chiefly when the partner is "tremendously in love" with the non-drinking personality of the alcoholic. (5) Regardless of whether a satisfactory sexual adjust-

ment is established at marriage, if the first method of meeting this problem was with alcohol, the patient will still at intervals, resort to long periods of heavy drinking.

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TECHNIQUES AND DYNAMICS OF MULTIPLE PSYCHOTHERAPY*

BY RUDOLF DREIKURS, M. D.

All forms of psychotherapy where several therapists treat a single patient simultaneously may be considered to be "multiple psychotherapy." Although new in private practice, similar techniques have been in clinic use for a long time. The child guidance clinics which Alfred Adler and his co-workers established in Vienna in 1920 practised not only group therapy, but also multiple therapy.[1] Parent and child were counseled jointly by the psychiatrist and a second counselor, either a social worker or teacher; the client's problems were discussed in his presence by the counselors whenever emotional blocking or resistance prevented a direct approach. Children, in particular, responded more readily when explanations of their behavior and suggestions for possible changes were not directed at them, but were discussed in their presence. Staff conferences in hospitals can also be considered a form of multiple therapy if the attending physician presents the patient and discusses his problems with other staff members. Group therapy often allows the participation of several therapists. Hadden[2] describes the participation of more than one doctor (student) in group therapy as a means of teaching psychotherapy. The writer's own experience in the psychiatric clinic of a medical school has demonstrated the effectiveness of supervised psychotherapy through joint discussions of the instructor with student and patient; each student in training presents his patient, and the supervising faculty member discusses with him the dynamic data evolved during the preceding interview which the student had with the patient. Whitaker, Warkentin and Johnson[3] have experimented for several years with a technique of psychotherapy in which two therapists treat one patient.

The writer's present interest in multiple psychotherapy was aroused by the rather surprising results of two incidents. A very difficult patient with psychosomatic disturbances who had been completely resistant to psychotherapy, even denying the need for psychiatric treatment, responded unexpectedly to a presentation

*Presented at the 105th annual meeting of the American Psychiatric Association, Montreal, Canada, May 27, 1949.

of his case to a class of medical students. The group discussion about his case marked the beginning of his co-operation.

The first introduction of multiple psychotherapy into the writer's private practice was the result of an emergency. It became necessary to train an assistant to take over the practice for a contemplated absence of the writer. Each patient was seen with the new psychiatrist, when the patient's problems, progress and difficulties were discussed in a joint session. Afterward the new psychiatrist made a few individual appointments, the results of which were again discussed in a joint interview. This permitted a smooth transfer of all cases under therapy to the new therapist. This procedure proved to be so effective that it was continued after the emergency period and has been continued for the past three years.

In 1931, similar needs, in an emergency situation, had stimulated the writer to introduce group therapy in his private practice. Under the pressure of an overcrowded schedule, three patients were asked for a joint consultation about one specific problem which they had in common. Only one group interview was contemplated. However, the patients expressed such gratification about the result of the discussion that they requested a continuation of these group interviews. Since then, group therapy has been an integral part of the writer's work with private patients, supplementing the individual sessions.

The principal dynamics of multiple psychotherapy are similar to those of group therapy. The methods share a variety of therapeutic factors. One is the patient's position as an observer of, and listener to, a discussion of his own problems, dynamics and attitudes; another is the less than usual personal relationship between patient and therapist and the atmosphere of a more objective approach. A more detailed comparison of the two methods is outside the scope of this paper.

Multiple psychotherapy seems to offer great benefits to the patient, and to the therapist as well. It can be carried out by two psychiatrists of equal experience, as a function of group practice, or it can be maintained as a training arrangement between a senior psychiatrist and his associates. The writer's experience was, until recently, mostly of the latter type. There are probably many ways in which multiple psychotherapy can be applied; it lends itself to various therapeutic procedures and approaches. Whitaker and

his associates[3, 4] applied it to psychotherapy based mainly on psychoanalytic concepts. The writer used the Adlerian approach, and his technique was, therefore, adapted to the specific needs of this approach. Characteristic of his technique is the regularity of one joint session with the consultant therapist after each two or three single interviews with the active therapist. (Whitaker et. al.[3] speak of "triangular interviews" and seem to use the consultant psychiatrist only for a limited period of time.)

In the writer's practice the patient is seen initially by the senior psychiatrist, who determines the nature of the problems, makes the diagnosis, and decides whether psychotherapy is indicated. The patient is then assigned to one of the associates. The latter then has two interviews with the patient to gather all the necessary basic information for the formulation of the patient's life style. This requires an investigation of the patient's earliest experiences within his family, his family constellation; it includes his position in the sequence of birth, his relationship to siblings and parents or any other person living in his household, the methods of training, early successes or failures. The recognition of the patient's earliest childhood relationships permits an understanding of his individual approach to others, stimulated by the experiences to which he has been exposed in his formative years. Early recollections offer another means of analyzing the life style or personality pattern of the patient. They reveal the conclusions which he drew from early experiences, his outlook on life, based on his concept of himself and of his role in society.

All the necessary data can be collected in two individual interviews, after which a joint interview is arranged between patient and both psychiatrists. The material obtained so far is presented and its significance discussed in detail. The patient may correct information if he finds the facts are misrepresented, or he may add some points. The main part of this interview is a discussion by both psychiatrists, defining the style of life of the patient. Following this, the patient is again seen by the active psychiatrist who reviews with him the conclusions of the first joint interview. He then investigates the patient's other experiences within his family, his school life, sex development, adolescence, social relationship and work experiences, up to the current problems and conflicts, with special emphasis on the "crisis situation" which brought on the

present symptoms. An understanding of the basic life style is used as a key to clarify past and present experiences.

After each two to three interviews, the material brought up is reviewed in another joint session. Generally the therapist who conducts the single interviews and sees the patient each time (the active therapist) decides on the frequency of the consultative joint interview, which should be arranged not less than every fourth interview; otherwise, the smooth co-operation between the two therapists may be endangered. In certain cases, particularly if the patient develops a negative attitude toward the active therapist, the other therapist may take over the active work. In this case the former active therapist takes on the role of the consultant therapist and is called in for joint interviews within the same intervals. Thus a wide flexibility is attained, and the therapy can be adjusted to various needs as they arise.

The advantages of multiple psychotherapy apply to all four phases which characterize dynamic psychotherapy. They may overlap or coincide; nevertheless, they imply different therapeutic mechanisms. The four phases are: (1) the establishment and maintenance of the proper interpersonal relationship between patient and therapist (the "transference" of the psychoanalytic approach); (2) an investigation of the patient's problems and the inner dynamics of his personality structure ("analysis" in the wider sense of the word); (3) the helping of the patient to understand himself (generally called "insight"); (4) the stimulation of the patient's reorientation to effect a change of his attitudes, outlook, goals and approaches—the principal purpose of the therapy. Multiple psychotherapy offers advantages in each one of these four fundamental steps.

1

The *relationship* between patient and therapist is greatly affected by the efforts of two therapists. The patient's willingness to accept a second therapist depends greatly on the self-confidence of the therapist arranging for such a procedure. Resistance was found only among the earliest patients, while serious reluctance to accept the procedure is rarely encountered today. If present, reluctance generally persists only until the first joint interview; after the patient has experienced in it the full advantage of this procedure, he is generally willing to accept both therapists. This willingness continues unless the patient becomes antagonistic

toward one of the two therapists. In these infrequent cases, hostility may be directed as frequently toward the active therapist as toward the consultant. The dynamics which lead to the resistance are always discussed in a joint interview in which the therapist not directly involved can always clear up the situation. It has always been possible to re-establish the normal procedure of multiple therapy, although the roles of the active therapist and of the consultant may be shifted.

The participation of two psychiatrists in his treatment strengthens the patient's confidence and increases his willingness to accept interpretations. It leads to an atmosphere of greater objectivity, where the personal bias of any participant can be more easily recognized and dealt with. This more objective and impersonal atmosphere does not hinder, but rather enhances, the progress of the therapy. This has some significance for the phenomenon of transference. It seems to indicate that the emotional attachment of the patient is *not* a pre-requisite for progress. Multiple psychotherapy does not preclude an emotional involvement of the patient with one or the other therapist. A strong emotional attachment to one therapist often reveals itself through the patient's resistance to the other. As already indicated, such situations are immediately met. Discussion and interpretation of the underlying dynamic factors either re-establish at once an atmosphere of more casual objectivity; or the therapist not involved takes over for the time being. In this sense emotional positive involvement is met in the same way as antagonism and opposition. Sometimes an apparent antagonism to one therapist is only a cover for the patient's desire to continue his main work with the therapist to whom he feels emotionally attached. Such aims generally retard the progress of therapy. As a rule, they indicate a drive for control of the situation, rather than a special need for emotional satisfaction. Critical examination and evaluation of the transference dynamics under multiple psychotherapy may produce significant data on the importance and the dynamics of transference in general.

The maintenance of a proper and friendly relationship between patient and therapist is also facilitated by the differences of the personalities of the two therapists. Each one has different personality traits, some of which are beneficial, some detrimental, in dealing with a particular patient. In almost every case, these vari-

ations of personality tend to supplement each other. If one trait in one therapist disturbs his relationship with the patient, certain supplementary characteristics of the other therapist come into play almost automatically, intensifying the effectiveness of the team.

2

The *analysis* of the dynamics of the patient benefits from the consultation between the two therapists. The chances of inaccurate conclusions are diminished; so are the dangers of overlooking certain aspects. While, by and large, a more experienced therapist contributes more, it is not unusual at all for a junior associate to point out mistakes and omissions. Divergent opinions are openly expressed before the patient. Such differences of opinion have no detrimental effect on the patient; on the contrary, he appreciates that a sincere effort is being made and finds it easier to accept final conclusions. Too often during individual therapy is a patient inclined to feel that the interpretations given are unfounded, even though they may be correct. The discussion between the therapists clarifies to him such interpretation; it is more convincing to the patient and offers a substantial guarantee of an objective evaluation of facts. Whitaker et. al.[4] suggest also a frank discussion of the two therapists in the presence of the patient, if one has difficulties during the therapy and reaches an impasse. His experiences confirm the observation that the patient appreciates an open admission of difficulties.

3

The discussion between the two therapists helps the patient to gain an *understanding of himself.* Emotional blocks often invalidate or preclude direct interpretation; not acceptable interpretation may even lead to argument and increase the resistance. Joint interviews are much more effective in such situations than individual sessions, which may force the therapist into a prolonged period of passivity. In the individual session, the therapist may have no chance to bring up his point and sometimes may find it even difficult to interrupt the patient's flow of emotionally-loaded speech; in the joint interview, he is in a completely different situation. The most distressed, anxious and restless patient is willing to listen while the two therapists discuss his problems.

The effectiveness of "listening in" has been observed in child guidance centers. The writer has pointed out[5] that most parents get greater insight into their own problems by listening to the discussion of similar problems presented by others. Similar observations are made in other fields. Lazarsfeld, Berelson and Gaudet[6] have observed that passive participation in conversations, i. e., listening to the discussion of others, seems to play an important part in changing and forming opinions. Moreno[7] introduced in psychodrama the figure of the "auxiliary ego" who, in a "mirror technique," helps the patient to realize his own position and attitude. The United States Army in its report on experiments made in regard to soldier's opinions[8] states that "giving the strong point for the 'other side' can make an argument more effective at getting across its message." In the writer's joint interviews the discussion is often arranged in such a way that one therapist presents the patient's point of view, his private logic, while the other offers an interpretation and evaluation.

Gaining insight and reorientation is a learning process. It requires repetitive, but also highly-varied, presentation of the material to be learned. As each therapist uses a different and varied approach based on his personality, the combined efforts of two therapists increase considerably the effectiveness of the learning process.

4

The period of *reorientation* seems to be considerably shortened through multiple psychotherapy. Various factors may contribute to the faster progress which has been observed. Some have already been mentioned: The patient's ability to comprehend and to accept insight is increased through the varied approaches; emotional blocks or disturbances in the personal relationship to the therapist are more easily recognized and more quickly resolved. The joint interviews are much more dramatic, and impress the patient more, than a sequence of individual interviews. The periodic recapitulation of the material obtained and of the progress achieved makes considerable impression on the patient. The monotony of repetition, often unavoidable in a series of individual interviews, is interrupted by the constant change of scene. During individual therapy, therapist and patient may become deadlocked in a point of investigation or discussion, and the therapist may find it difficult to extricate himself. The joint interviews al-

ways offer new angles and bring the situation into proper focus.

While the benefits which the patient derives from multiple psychotherapy seem obvious, the advantages for the therapist may depend on the method and approach which is used. A completely non-directive approach as implied in Freud's original form of psychoanalysis and catharsis, and more recently in the "client-centered" approach of Carl Rogers, may not need the support and the subjective relief which the therapist with a more active approach derives from multiple psychotherapy.

In multiple psychotherapy, the therapist's frustrations and difficulties, so often experienced in individual therapy, are almost completely absent, or at least are kept to a minimum. Whenever a feeling of inadequacy or discouragement may affect the therapist, the discussion of his therapeutic predicament with his co-worker—in the presence of the patient—may quickly dispel it. The frank, open and sincere atmosphere of such discussion keeps personal pride and concern for prestige to a minimum and dissolves any despair, discouragement or ill feeling on the part of either patient or therapist. There is no question of uncertainty or insecurity left for the therapist. Any personal involvement through occasional concern for his prestige, through a dormant desire for authority, through an antagonism or secret hostility provoked by the patient or his problems, is revealed in the joint interview, is openly discussed—and is dispelled. The open discussion of mistaken attitudes on the part of the therapist, as well as on the part of the patient, permits a stable equilibrium between patient and therapist, and establishes a relationship based on a sense of equality and mutual respect. Such a relationship seems to present the best basis for co-operation and provides the most favorable therapeutic atmosphere.

Multiple psychotherapy has particular value for the training of less experienced therapists. It is probably more effective for didactic purposes than controlled therapy or the use of wire recorders. The training is not restricted to verbal instruction; it is provided in the actual setting through action and practical experience. Learning on the job has been recognized as the most successful training method. The therapist-in-training functions actively and efficiently almost from the beginning.

The combination of more and of less-experienced psychiatrists, of psychiatrists using different approaches, of psychiatrists and

clinical psychologists, may well become a trend in the development of group psychiatry, as Oberndorf[9] pointed out recently. In such a group setting, multiple psychotherapy may easily be practised and be advantageous to therapist and patient alike. The patient would receive the services of highly-trained psychiatrists without demanding their full time. On the other hand, the method would give the senior psychiatrist sufficient time for his other assignments, for teaching, research, etc. This is of all the greater importance at a time when we must think in terms of providing more psychotherapeutic facilities for the population and of arranging the best time-economy for the insufficient number of highly-trained and experienced psychiatrists.

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DISCUSSION

By Sybil Mandel, Ph.D., Baltimore, Md.

Dr. Dreikurs' stimulating paper brings to mind analogies in related fields as well as a number of questions.

To consider just two of the analogies, a person who, in the position of school psychologist has served as counselor and, in more recent years, as

mental hygiene consultant in public health departments has become familiar with similar therapeutic teams. In the earlier work, the therapeutic process was observed when students' problems were handled jointly by the clinical psychologist and a teacher who had been oriented in the techniques of Individual Psychology by the same psychologist. As for the second analogy: In the Baltimore City Health Department a few of the public health nurses are beginning to deal with the emotional aspects of child development, helping mothers with problems which have arisen or—through anticipatory counsel—with situations before they arise. When the mental hygiene consultant is called in, a three-sided conference results. As Dr. Dreikurs has implied, this frequently tends to mitigate any vestigial authoritarianism in the nurse's attitude. On the other hand, the mental hygienist must take pains to preserve the positive factors in the nurse-mother relationship.

So much, briefly, for analogies. May I deal solely with one question, the first which comes to mind and which concerns the patient-therapist relationship? Assuming, as many of us do, that, at some time at least during treatment, the patient experiences his relationship to the therapist as that of the infant to the mother-person, can multiple psychotherapy be considered within the framework of such an ideology? It seems to me that the answer is an affirmative one since, in the words of Alfred Adler, "the second important function of the mother is to spread the child's interest" to others in his environment. At what an early period in the infant's life do we see a euphoric response to the sight of a loving father, an older sibling or some other familiar figure? If the emotionally-immature infant can so relate himself, why not the emotionally-immature adult?

We look to Dr. Dreikurs and his colleagues for further study in this field, which is of practical importance not only to psychiatrists but to those auxiliary workers who, to a great extent, are dependent on their findings.

Discussion

By Alexandra Adler, M. D., New York, N. Y.

Dr. Dreikurs' vivid description of his technique of multiple psychotherapy stimulates the discussion of certain problems which have been on many psychiatrists' minds for some time: To begin with: Dr. Dreikurs' method again proves that hardly ever is there *only one* possible approach in medical therapy, that to believe so denotes an error. This has certainly been the case in the field of psychotherapy. We can trace this erroneous tendency back to times as early as the eighteenth century when the unquestionable therapeutic achievements of Mesmer were attributed to the application of one rigid technique exclusively, namely to the use of so-called animal magnetism through Mesmer's magic hand. It took a long time before the essential factors, namely those now commonly attributed to hypnosis or suggestion, respectively, were recognized and separated from all the additional

paraphernalia used by Mesmer. Then again there were long decades of discussion as to whether it was suggestion or persuasion only which should be used in an effort to influence a patient's personality.

Later again, through several decades, our generation has witnessed the development of, and adherence to, a rigid form of psychotherapy. In this form, it was considered essential to have the patient come five times weekly, for 50 minutes each time, in a specific transference setting which postulated an exclusive, close relationship between psychotherapist and patient, without which no success was to be expected. At present, we witness a liberation from rigid attitudes and the application of a flexible approach in many settings. Dr. Dreikurs has stressed the fact that his technique of multiple psychotherapy was used in Alfred Adler's child guidance clinics many years ago. It was there that many observers were greatly impressed by the importance of having the patient realize the social implications of his deviations. When his problems were discussed in a group setting with the teacher, parents and others, the child had his first revelation that he was not fighting a private fight but that the whole of society was implicated. This took his problems out of a small horizon and made them applicable to the other important problems of life. It brought reality closer to the child and did so through the lively experience of group discussion.

My own experience in this field of multiple psychotherapy, with *adults*, leads to the same conclusions as Dr. Dreikurs'. As chief of the psychiatric clinic of Mount Sinai Hospital in New York, I see every patient first before I refer him to the staff for treatment. Whenever a rather difficult problem, such as a question of discharge, arises, or before presentation of the patient at conference, I see the patient again with the physician-in-charge. Here, too, it has happened—though very rarely—that the patient afterward, somewhat defiantly, has said to his physician that what the chief of the clinic had said was exactly the right thing. But such an incident could always be used to advantage for the patient. To see God in one's psychotherapist is quite evidently undesirable and, incidentally, probably happens much less frequently than some psychotherapists think. We, too, occasionally observed lasting improvements after presentation of the patient before the whole staff where everyone was welcome to talk to the patient. This, of course, is possible with psychoneurotic patients only if the staff is well-trained in experience as well as in tact. No patient resented this procedure afterward, though most of them were somewhat reluctant at first when they were asked to consent to a discussion of their cases in their presence with the staff.

One would think that such team work is possible only if the doctors belong to the same school of thought. This, too, proved not essential. In my work with disciples of various schools I have come to the conclusion that the matters which count in the handling of the patient are, in addition to

other prerequisites, extensive experience, intellectual curiosity and a love of the truth. Adherence to any particular school of thought cannot provide any substitute for this. Consequently, in dealing with a well-trained staff, I have never experienced any fundamental divergence of attitude as to the actual handling of the patient, though we may occasionally differ in our concepts as to the causation and psychodynamics of the various specific symptoms. This, however, never interfered with our evaluation of prognosis, choice of certain practical suggestions or handling of acute exacerbations. The procedure of multiple psychotherapy is not meant to supplant any other approach. It should be used in private practice whenever the particular setting—which includes the make-up of patients *and* doctors as well—warrants such application.

Finally, as Dreikurs has stated, the advantages in the training of the young doctor by the more experienced colleague are, of course, quite obvious and, in certain aspects, superior to the use of such devices as listening to sound records, and the like. Multiple psychotherapy demands the active participation of the physician-in-charge in his role as psychotherapist, which active participation, as is well known, is of primary importance in any teaching procedure.

OCT.—1950—L

OBSERVATIONS AND OPINIONS CONCERNING COMPLICATIONS AND CONTRAINDICATIONS IN ELECTRIC CONVULSIVE THERAPY

BY ROBERT L. WILLIAMS, M. D., AND S. EUGENE BARRERA, M. D.

Many observations have been published since the early work of Cerletti and Bini[1] in 1938, concerning the indications for, and results of, electric convulsive therapy. There have been fewer reports emphasizing the contraindications for such therapy.

There has been definite lack of agreement as to what actually constitutes a "contraindication." The difficulty arises from the fact that one must decide between two hazards; the risk attendant upon the possibility of aggravating some co-existing organic disease, outside of, or within, the central nervous system, and the risk of not relieving a serious mental illness when the relatively certain means of doing so is at hand. Under such conditions, one hesitates to state categorically that a particular malady is always a basis for not giving electric shock, particularly if such an attitude would deprive large numbers of psychiatric patients of possible therapeutic help. As total experience with this treatment has increased, there is a growing tendency to apply E. C. T. to patients if the psychiatric indications are convincing, and to assume the added risk from possible aggravation of co-existing disease—except in relatively few instances.

It has seemed important, therefore, to review the literature dealing with the subject of contraindications and to formulate the present writers' own ideas in this field, based upon experience with some 14,000 shock treatments during the past two and one-half years at the Mosher Pavilion of the Albany Hospital, Albany, N. Y. No attempt will be made to present a statistical study, but the literature has been carefully reviewed, and in the light of this, and of the writers' own wide experience, they feel that certain conclusions regarding the contraindications and complications of electric convulsive therapy are warranted. Comparison of the early literature with the recent reports, and especially with the fine survey by Kalinowsky and Hoch,[2] reveals changing opinions concerning the actual contraindications to this therapy.

It is apparent from the earlier publications that the workers felt that a patient must be in excellent physical condition before undergoing the supposed rigors of electric shock treatment. A pre-

liminary paper submitted by Barrera and Kalinowsky to a leading medical journal was returned with a note saying, "There is little doubt but that the passage of currents of 300 milliamperes through the brain would be a highly dangerous procedure and in all probability result in fatality to the patient."

Since that time many workers have reported a variety of complications in the course of electric convulsive therapy. These have involved nearly every system of the body; and from them, one is able to gather certain facts about contraindications. As the number of treatments given has increased to the astounding figures it must now have reached, it has become more and more apparent that certain serious complications, formerly considered as completely excluding E. C. T., stood out as isolated instances among the galaxy of uncomplicated cases, and hence, were merely instances to be weighed and considered in the light of a larger number of uncomplicated cases. For instance, it is interesting to know how much weight to give to the report of an instance of activation of tuberculosis followed by fatal hemorrhage as reported by Damino.[3] This was an isolated case—although others have since been reported—and had to be evaluated when compared with a series of cases so treated. The writers' own experience, as will be mentioned later, has been more favorable in treating cases where tuberculosis was present. A review of the complications of the therapy will give some idea of the contraindications which should be considered.

Musculoskeletal

By far the largest number of complications have been reported in the musculoskeletal system. The commonest is biting the tongue and lips, and this is followed by dislocation of the jaw. Although no careful statistical summary has been found in the literature, it is probable that compression fracture of the vertebral bodies is the next commonest complication. In the writers' own experience, fractures of the ribs and long bones probably occur next in frequency in complications involving the musculoskeletal system. Loosening of the teeth or loss of teeth has been seen in several of the writers' cases and has been reported in literature.

Cardiovascular System

Complications in the cardiovascular system are rare but do occur. The comparatively few cases of death associated with elec-

tric convulsive therapy seem to have been attributed to cardiovascular complications. About two dozen papers have appeared in the past 10 years describing such complications. Kolb and Vogel[4] found cardiovascular complications occurred at a rate of 0.5 per thousand. These include vascular collapse, cardiac decompensation, auricular fibrillation, onset of persistent hypertension, coronary thrombosis, various transient arrhythmias, and in one case, a reactivation of a pre-existing endocarditis. Impastato and Almansi[5] reviewed the literature and discussed cardiovascular complications in over 2,000 cases. In the writers' own series, one patient, treated at this center, developed a severe nosebleed. Conjunctival hemorrhages are apparently rather common. Cerebral vascular lesions have been of considerable concern and they have been seen in the writers' clinic. Kaldek[6] reported a case of transient hemiplegia following treatment. One patient in the writers' clinic, a 52-year-old white male with a history of previous hemiparesis, developed signs of a new vascular lesion after his fourth treatment. At the time treatment was started, he had no neurological signs of significance and his blood pressure was 210/130.

Another patient, a man in his late fifties, was seen because of a severe agitated depression. He had a history of hemiparesis three months prior to treatment and still had residual signs, including slight weakness and reflex changes on one side. After his first electric convulsive treatment, he promptly developed a transitory hemiparesis on the same side as the previous lesion. Shock therapy was discontinued, but he failed to respond to an intensive antidepressant medical regimen. The patient's family was advised of the risk associated with further shock treatment; however, in consideration of his clinical psychiatric condition, they requested that it be re-instituted. Treatments were begun at the rate of three a week. The patient received a total of six, made a good recovery from his depression, and developed no additional signs of hemiparesis.

Vascular accidents are exceedingly rare when one considers the large number of hypertensives and severe arteriosclerotics treated. Feldman et al.,[7] reported 53 patients, each over the age of 65, who were successfully treated in the present writers' clinic. Since that time, the number of such patients has increased five-fold. The oldest patient treated at this center was 94. Two cases of thrombophlebitis of the leg have been seen recently in this clinic when pa-

tients were receiving electric convulsive therapy. It is difficult to say what the causal relationship may have been. Treatment was temporarily discontinued in both cases, despite clinical need, because of the possibility of embolism.

Respiratory System

Respiratory complications are not common. The apnea associated with the epileptiform seizures should not be considered a complication unless it becomes prolonged and requires some special therapy to restore normal respiratory function. All such cases of prolonged apnea at this center have responded to artificial respiration and oxygen. The complication of prolonged apnea seems to occur most frequently with abortive or minor type seizures. This observation seems to agree with those of other workers. Muller,[8] and Holzer et al.,[9] both report increased frequency of respiratory difficulties after subconvulsive or abortive responses. Kalinowsky and Hoch[3] report the routine application of artificial respiratory movements after each treatment as a prophylactic measure for respiratory embarrassment.

Other respiratory complications are not common in the literature. Kalinowsky and Worthing[10] report one case of pulmonary abscess associated with electric convulsive treatment. Pacella[11] reports two flare-ups of pneumonia in one patient under electric convulsive treatment. At this clinic, a similar instance was observed in one patient who developed pneumonia during treatment, which was reinstituted after the infection had apparently subsided. There was a second bout of pneumonia. The patient was suffering from involutional depression, and eventually received a complete course of electric therapy, and responded favorably.

Recently, one patient in this clinic developed pleurisy with effusion after a rib was fractured during treatment.

Laryngeal spasm, atelectasis, or other respiratory difficulties have not been seen here.

Gastro-Intestinal System

The only gastro-intestinal complication noted at this clinic was the frequent occurrence of post-treatment nausea and vomiting—usually a few minutes after treatment and seldom persisting longer than two or three hours. As a rule, no specific treatment for this was instituted. It is presumed that the mechanism is a

central nervous system one. In one or two cases where the sensation of nausea persisted through the day a venoclysis of 5 per cent glucose in physiological saline was beneficial. A few patients complained of bouts of diarrhea, but the causal relationship is not clear.

Complications in the genito-urinary system have not been reported in the literature. An unusual complication was recently observed in the writers' clinic in a middle-aged colored woman. She was suffering from a moderately-severe involutional depression. Following her second electric shock treatment, she began to complain of distention and abdominal discomfort. Over 24 hours this became increasingly severe. Her abdomen was found to be markedly distended and diffusely tender to palpation. Her temperature was only slightly elevated, but her leucocyte count was 20,000. An x-ray of the abdomen showed the "step-ladder" effect suggestive of intestinal obstruction. Review of her history called attention to a urethral stricture for which she had been treated by weekly dilatations. Exploratory laparotomy revealed a ruptured bladder with about 1,500 cc. of urine in the peritoneal cavity. The laceration was repaired, the patient made a good recovery and was able to complete her course of electric treatments.

In retrospect, it was felt that the patient had probably gradually developed increased retention of urine and that the convulsions had caused rupture of the distended bladder. It is obvious that this complication might have been prevented, had the staff given more weight to her history of stricture, and had the floor nurse been more diligent in her pre-treatment preparation of the patient. This preparation includes having the patient void before entrance into the treatment room.

A number of cases of post-treatment amenorrhea developed and persisted for several months. There was apparently no correlation between the amenorrhea and either the psychiatric diagnosis or the number or frequency of shock treatments. About half the patients were suffering from schizophrenia and about half from psychoneuroses.

Nervous System

Complications referable to the nervous system may be grouped as purely neurological or purely psychiatric. Neurological complications following shock treatments are apparently very rare.

One case of peroneal neuropathy was observed in this clinic. It is possible that the nerve may have been traumatized by pressure at the popliteal space during the convulsions.

The incidence of spontaneous convulsions following electric shock treatments is extremely low. Late convulsions have been reported by Pacella and Barrera[12] in two patients who apparently had definite convulsive patterns previous to convulsive therapy. Since that report, spontaneous convulsive seizures following treatment have been seen in four cases in this clinic. In all four, the seizures developed within six months of treatment. Unfortunately, follow-up contact with these patients was lost, and it is not known whether the seizures ever occurred again.

Psychological Complications

A fairly common psychological complication was excitement and overactivity during the course of treatment. This phase may be very violent and dangerous to the patient and operator if not properly controlled. Administration of from 0.25 to 0.5 Gm. of sodium amytal has controlled these reactions. This is injected intravenously following the cessation of convulsions and as soon as respirations are restored. It is used in patients who have been known to have had previous phases of excitement following treatment or in patients who are being treated for the first time, who are unduly tense, and in whom the operator anticipates post-treatment excitement. Actually, this anticipation often depends more on a "hunch" than on clear-cut psychiatric observations. It does seem that patients who are suffering from paranoid conditions or patients who have considerable underlying anxiety and fearfulness of the treatment are more prone to develop post-seizure excitement.

In certain cases, the patient's pre-treatment state was definitely made worse following electric shock. Schizophrenics who were maintaining contacts with reality often did poorly. Chronic hypochondriacal neurotics did not respond favorably.

Memory impairment for varying periods was a common complication. Persistent memory loss was seen, but, fortunately, this was rare. If patients were warned of the possible memory loss before commencing a series of treatments, there seemed to be much less apprehension when confusion or memory loss occurred.

Contraindications and Warning Signs

After reviewing the complications reported in the literature, and those in the writers' own experience, they can accept certain conditions as definite contraindications and others as calling for precautions. Musculoskeletal system complications, such as fractures, do not constitute definite contraindications, although patients with recent fractures must not have E. C. T. unless curare is also used. The writers have used curare in this clinic in about 20 cases in this series, and it has caused no serious complications. In almost all instances, the seizures have been successfully "dampened."

Cardiovascular contraindications are actually few. The writers feel, as others do, that a recent myocardial infarction is a definite contraindication. When the electrocardiogram shows evidence of myocardial damage, it is the policy at this center to request medical clearance before proceding with shock treatment. It is important to evaluate the laboratory report of myocardial damage in relation to the clinical cardiac and clinical psychiatric condition. Often the psychiatric indications for treatment outweigh other considerations. Congestive cardiac failure is apparently a definite contraindication until cardiac compensation is restored. In one case recently, it was necessary to give electric convulsive treatment while the patient's cardiac compensation was under treatment. This patient was so severely agitated that it was impossible for her to follow the usual restrictions of activity for congestive failure, and, only after she had received six shock treatments, was she able to rest enough to restore cardiac compensation.

Hypertension is not a definite contraindication. The initial rise in blood pressure after a shock is potentially dangerous, but most workers feel that the indications in a clinical psychiatric disorder usually outweigh the danger of this rise. Some recent observations suggest that hypertensives treated with electric convulsive therapy show rather often a sustained fall in blood pressure during and following therapy. On the other hand, several cases of sustained hypertension have been reported following treatment. Patients who have had recent cerebral vascular accidents are definite risks. Because of the possibility of embolism, the writers have not treated any patients with known active inflammatory peripheral vascular disease. Pregnancy, or the postpartum period, have not been contraindications. The writers have treated pa-

tients, with no complications, as early as 48 hours after delivery.

The writers no longer consider tuberculosis a definite contraindication; they have treated half a dozen patients who were diagnosed as arrested and an equal number of active cases; and there was only one adverse reaction in this series. Indeed, several of the active cases of tuberculosis were benefited in that shock therapy rendered them able to carry out their rest cures. An example is a middle-aged white male with moderately advanced pulmonary tuberculosis of the lung. This patient was depressed and extremely agitated, making it almost impossible for him to obtain any rest. He had eight electric shock treatments, after which his agitation and depression diminished considerably and he was able to continue his bed rest satisfactorily. There was no change in the status of his pulmonary lesion following shock treatment.

In view of the writers' experience and that reported by Pacella, it must be anticipated that patients suffering from pneumonia may not do well as far as their pulmonary infection is concerned when given electric convulsive treatments.

There are apparently no particular contraindications referable to the gastro-intestinal system, or to the genito-urinary tract. It is important to check patients for retention of urine before treatment.

Disease of the central nervous system has posed only a few contraindications to treatment. Organic brain disease is not always a contraindication. Tomlinson[13] reports beneficial effects with electric shock treatment in cases of central nervous system syphilis. The present writers have had similar good symptomatic results in cases of syphilis and of degenerative brain disease, including senile and arteriosclerotic psychoses. Only patients who had marked affective disturbances were treated. In several instances, they improved enough so that they could be cared for at home. Several others showed enough improvement to make them more manageable on the ward. In a surprisingly small number of cases, memory disturbance and confusion was increased.

Peripheral neuritis was not a contraindication to further treatment. Such neuritic patients were treated in addition with high vitamin therapy, physiotherapy and rest as indicated.

Psychiatric contraindications are not conclusive. Depressed patients in whom there were strong, so-called psychopathic trends did not respond well to treatment. Patients who showed early

schizophrenic reactions but were still in good contact often became frankly psychotic when started on electric convulsive treatment. It seems that the fragile balance that these patients are maintaining with reality is destroyed when the psychic trauma of electric shock is introduced. Of course, when this occurs, it is necessary to continue treatment for eventual improvement.

Psychoneurotics, as a group, generally respond poorly to electric convulsive therapy. Patients who are already concerned and anxious, lest they lose their "sanity," frequently become more distressed when they begin to experience the sensations of unreality which are common after shock treatment.

Summary and Conclusions

An attempt has been made to evaluate the present status of complications and contraindications to electric convulsive treatment, by an analysis of the complications reported in the literature and by observation of the writers' experience for the past two and a half years in about 14,000 treatments at this center. It is concluded that there now appear to be fewer contraindications than was believed in the earlier days of this therapy.

Definite contraindications include congestive heart failure, recent myocardial infarctions, and aneurism of the aorta. There is significant risk of making the clinical physical condition worse in cases of recent cerebral vascular accidents, acute respiratory infections, and active peripheral vascular disease. Recent fractures require the use of curare with shock therapy. Psychiatric contraindications are inconclusive.

In each case, one must evaluate the psychiatric indications for convulsive therapy and decide whether they outweigh any co-existing disorder which might increase the risk of treatment.

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EDITORIAL COMMENT

PREVENTION—ALWAYS A TIMELY SUBJECT

We have recently heard discussion about the merits of preventive war, and although we do not propose to add our voice to the controversy, we believe it is a question of peculiar psychiatric interest. It may well be wondered if there would be any occasion to discuss preventive war at all if it were possible to interest the world's peoples as a whole in preventive psychiatry. For war—preventive or otherwise—is a symptom of mass emotional disorder. And one task of preventive psychiatry is to prevent mass emotional disorder.

Preventive psychiatry is that division of general preventive medicine which pertains to our own medical specialty. It is years behind in concept, and decades behind in development, the better-known branches of preventive medicine. It is comprehended loosely, and covered somewhat ineffectually, by public and private efforts toward mental hygiene and by the work of the orthopsychiatrists.

Psychiatry shares the two principal aims of general medicine, the curative and preventive. Curative and ameliorative psychiatry is the field of the hospital and the doctor's office; its practitioners are the psychiatrist and the members of the ancillary disciplines, such as the psychiatric nurse, the psychiatric social worker, the clinical psychologist, the recreation or occupational therapist. Preventive psychiatry has the whole world for its field; its practitioners would seem of necessity to be the same as the practitioners of other preventive medicine, the world's peoples themselves, although the need for professional leadership in preventive psychiatry is certainly no less great than in other preventive medical fields.

We tend to forget just how deeply modern preventive medicine has penetrated western culture and how greatly it has changed the course of human life. Pure water supplies; pasteurized milk; fresh meat protected from flies; clean, unadulterated preserved foods of all varieties; commercial and home refrigeration of perishables; proper disposal of sewage and refuse; insect control; and innumerable other factors of daily life which we accept as

matters of course, have lowered disease and mortality rates tremendously within living memory. Man in America still falls ill; he is still heir to mortality, however the consummation is postponed. But he no longer fears the yellowjack, the malaria and the black death which once wiped out cities and civilizations. He no longer fears the summer with its epidemics of diarrhea (summer complaint) and colic, which once slew his babies in great numbers. Insect and vermin control, uncontaminated water, clean food and milk have virtually wiped out these disorders. The work of wiping them out—and the fact is highly pertinent where preventive psychiatry is concerned—has not been the job of the doctor. Medicine determined the necessity, identified the disease organisms, discovered their carriers and worked out the means of control. But non-medical engineers handle our water supplies; technicians supervise the pasteurizing of our milk; non-medical personnel control and inspect the processing of our food supplies; engineers and technicians—in theory at least—supervise our sewage and garbage disposal.

At any rate, these major endeavors of preventive medicine are no longer medical responsibilities—whatever the status may be of such other matters as vaccination, typhoid and diphtheria immunizations, or public health employment of penicillin in the present campaign to eradicate venereal infections. Historically, as a matter of fact, public health was once far from a medical responsibility. When medical factors were involved, they were, like as not, considered to be in the field we now know as magic. From our present point of view, psychiatry has snatched much of this material to itself in the process of discovering scientific bases for magical happenings. Of the social practices of pre-scientific and even prehistoric days, magic appears to have been the ancestor of psychiatry. When the medicine man kindled his ghost fires, rattled his sacred knuckle bones and beat his eerie tatoos on the spectral drums, he was employing the medical psychology—such as it was—of his day to avert evils which he thought of in terms we should assign to psychiatry. The conjuring of the witch doctor might have been aimed at the demons of plague, the gods of famine or the fearful lords of battle-panic. His enemies, as he saw them, were forces he considered demonic and which we, today, would consider for the most part psychogenic. When the Roman augurs scanned the sky or examined the entrails of slaughtered animals,

their procedure was a primitive sort of preventive psychiatry—with the emotional problem of military morale often the central issue. When our less remote ancestors not so long ago first closed their doors and windows against the *mala aria*, the bad (night) air, they were practising something like psychiatry in excluding the demons which caused the ague. When the evil was assigned to the air itself, the problem moved from psychiatry toward the domain of physical medicine. When the illness of *mala aria* was traced at last to the Anopheles mosquito, malaria prevention became, first, a problem wholly within the field of physical medicine, then a question of insect control to be turned over to the engineers. So with the demons which caused yellow fever, the bubonic plague and typhus. Preventive medicine became more and more removed from the concern of psychiatry's precursors.

Such of the medicine man's problems as did not resolve themselves in the field of physical medicine became more often than not the preoccupation of the theologian or the judicial authorities. A man pursued by personal Erinyes or by the Furies was a problem primarily for the priest, the jailor or the police before it was finally returned, less than two centuries ago, to the modern representative of psychological medicine. But in re-assuming responsibility for the individual's psychiatric problems, the modern medicine man has not yet fully re-assumed the ancient public health burden of his tribe's emotional wellbeing. He has left much of it to religion—where the procedure is moralistic—and much of it to such unsystematized endeavors as political and patriotic rallies, or the music of army brass bands. And much of the burden has remained in the home and in the schools—to be shouldered by parents and teachers who are less than well-trained to carry it.

We think psychiatry here could learn from the history of general preventive medicine. That history has included much scientific testing of popular belief or folklore—without prejudice because an idea was old or because it was supported by rationalized superstitution. We think psychiatry, too, needs to approach its share of public health problems with the realization that the old idea or the traditional practice is not necessarily worthless and that the new is not necessarily good. Hackneyed ideas—including this one—are sometimes hackneyed because they are sound. Superstitions may be strengthened by a core of hard, empirically-tested fact. It seems rather more than likely that the superstí-

tious taboo against walking under a ladder arose from fighting men's fears of ritual contamination by walking under menstrual blood—something one would go far to find on a modern ladder. But falling paint pots, carpenter's tools and the possibility that the whole thing may slip and crash down on one's head make an altogether awe-inspiring modern rationalization for not walking under a ladder; it is easy, in fact, to think of many safer places than a spot directly under one. If rational men no longer have cases of the horrors from the realization that they have inadvertently walked under ladders, rational men do not go out of their way to find ladders to walk under.

Psychiatry, unthinkably old in primitive practice, is very young as a science; it is far behind epidemiology, internal medicine and surgery in the matter of testing for scientific approval or discard, pertinent items of our emotional, intellectual and institutional inheritance. From some few, psychiatry—with the aid of ethnology, sociology, and even modern mathematics—has removed all factual basis by demonstrating emotional, irrational origins. The magic, that is the good luck or bad luck, residing in numbers has been largely dispelled by psychiatric and other demonstration of its purely symbolic—almost, in fact, sschizophrenic—genesis.

On the other hand, psychiatry has contributed to, and confirmed, scientific data in support of many institutions and beliefs which rested on custom, moral fiat, or strictly religious authority. For instance, many alternative marriage systems to our own either exist in other modern societies than ours or have existed in the historic past. Suggestions for modification or changes in observance of our own marriage customs have been made for centuries by reformers with backgrounds ranging from theology to economic determinism. Far from branding our customary behavior as purely superstitious, psychiatry contributes an important and timely warning here that we would do well to make haste very slowly indeed in recommending drastic changes in our marital customs. Psychoanalytic ethnology has raised, for example, grave doubts as to whether the customs of this or that other land make for any greater human happiness or any increased human usefulness over our own. And psychiatric investigation of our own institutions has indicated that they serve needs inherent in our society if not inherent in humanity itself. Here is a reasonably clear instance where the limitations and frustrations of existing prac-

tices were so evident that advancing science could see little intellectual barrier to experimentation and change. It has required modern psychiatry to determine that intellectual justification is not justification enough for great interference with human lives or long-established human customs. Many intellectually questionable customs are adapted with such a delicate balance to meet inner human needs that we interfere drastically with them only at considerable hazard.

When the Communist minority seized power in the Russian Revolution—according to the now familiar pattern of a "people's democracy"—its materialistic exponents proceeded to attempt virtually to "abolish marriage" as a bourgeois institution, based on superstitution and unsuited to human needs. Although Russian history since that day has been more or less obscure, the results of this experiment are plain enough; conventional monogamous marriage was reinstituted and refortified by the might of the law; it met social and emotional needs which were unsatisfied after the attempt at abolition. So far as we know, psychiatry—even "Marxist psychiatry"—had nothing to do with either the initiation or the abandonment of this experiment. Our point is that if today's psychiatry had a voice in any similar situation, that voice would be raised against such drastic experiments with public mental health. Scrutiny of marriage, as of all other human institutions, is one of the serious problems of psychiatric public health. The evidence that we need better emotional attitudes, as well as other changes in some social and legal phases of the marriage situation, does not have to be sought out; it is apparent in divorce court and police court statistics and in psychiatric case histories. But the warning against drastic change of established custom by fiat is at least equally plain; the process of individual psychotherapy is a slow and cautious one; there is every reason to think that mass psychotherapy in the form of preventive psychiatry calls for at least as much slowness and as much caution.

There are illustrations closer to home—if less spectacular than the experiment with marriage in Russia. The cradle was a standard piece of household furniture in the homes of our great-grandparents, if not of our grandparents. Baby was soothed to sleep by rocking, and perhaps by lullabies, while mother mended the family socks or did fancy work. He was picked up and comforted when he cried; he was nursed; he sucked on a pacifier or a sugar-

tit; he was handed around and kissed and loved—and put back regretfully in the cradle when the sandman closed his eyes.

Then came modern medicine, with its antisepsis and asepsis, its vaccinations and immunizations, its precautions and its prohibitions. Research and specilization developed. The obstetrician, who banished pain and puerperal fever from the childbed, was followed by the pediatrician, who ended the childhood scourges of colic, summer complaint and diphtheria. To join the pediatricians, came the (non-medical) psychologists from the field of education—the first great geographers, cartographers and meteorologists to pioneer in the exploration, the map-making and the climate of the visible surface of the human mind.

Most of our generation and most of our children were born in the world of the pediatrician and the general psychologist—Arthur Guiterman's era of the "antiseptic baby" and the "prophylactic pup." Baby was no longer rocked or picked up; four-legged cribs replaced cradles; children have to learn to sleep, and they might as well start as babies. If they are comforted when they cry, they will cry to attract attention. The pediatrician observed that the celluloid pacifier was seldom aseptic and that the sugar-tit couldn't be; the psychologist noted that the habit of sucking was a habit to be broken anyway. When the pediatrician began to wonder, in addition, if too much sucking might not deform the infant's teeth, baby lost two traditional comforters.

Baby lost the breast when it was discovered that it was easy to pasteurize cow's milk and boil bottles and rubber nipples, and difficult to apply these same processes to human mothers. He lost innumerable kisses and caresses as general knowledge of infectious and contagious diseases increased. It may be significant of the trends of that day that there was much speculation in "popular scientific" circles about laboratory production of test-tube babies. A biologist produced a "frog without a father." If a frog, why not a baby? But if babies were not actually turned out in laboratory or machine shop, it was at least possible to treat them as if they were small machines—and many were so treated. Mother treated baby the way father treated the new Ford; standard processes of fueling, cleaning and lubricating were practised on standard schedules.

In our day, psychiatry, particularly child psychiatry, has discovered that babies are not little machines and are harmed by

being treated as if they were. Many, if not most, child guidance experts now favor rocking a child when it is sleepless. And a powerful and growing group, the Cornelian Corner, led by psychiatrists and supported by much scientific evidence, is campaigning militantly for a return to breast-feeding. Babies, it seems, need warmth and cuddling, and human affection and attention. Serious individual emotional disorders, and possibly some of the serious mass emotional disorders of our time, appear to be possible results of mechanizing the child.

The psychiatric branch of medical science has been reversing the trend of pediatrics and general psychology until the wheel has turned almost full circle. The human mind has proved to have depth as well as surface; the geologists, the mining engineers and the undersea explorers have joined the geographers and mappers of the mind to disclose a vastly different structure, with vastly different requirements, from the plainly visible surface intellect. We have seen this sort of thing in other branches of science and other kinds of thinking. In the early days of dietetics, we learned that spinach was the food richest in the essential mineral, iron, and we inflicted huge quantities of it on helpless children—deriving, it must be admitted, at least minor compensation in the creation of Popeye, the sailor man. Today, we know that numerous other foods contain large amounts of iron, some of them more "available iron" than spinach. Today's pediatrician may—and sometimes does—say with a clear conscience, "No, don't make him eat spinach; I'd as soon eat grass myself." If one can detect a tendency to sneer at such reversals of opinion, we can remind ourselves that it is by such methods—elucidating, testing, accepting and discarding—that true scientific progress is made.

Any student can compile a list of such reversals in psychiatry. The snake pit is the traditional example of long-ago discarded efforts to scare mental patients out of their aberrations; the lash is the long-abandoned traditional method of punishment for them. But there are some psychiatrists who wonder if some unappreciated curative factor in these ancient cruelties is not responsible for some of the good results of our most modern shock and operative therapies. Similarly, we no longer attribute lunacy to the moon; but—numerous observers suspect—a large enough proportion of disturbed patients can be excited by light at night to have given more credulous observers in the distant past something re-

sembling a rational basis for assuming a cause-and-effect connection.

To the same point, we no longer believe that a strawberry nevus birthmark can be caused by a prospective mother's' dietary indiscretion, or that talipes is the result of her encounter with a goat, the devil in person, or a horse. We may very well maintain firm skepticism about such old wives' notions as that idiots are born because their mothers were frightened by big black spiders, little yellow dogs or steam-spouting locomotives. But the progress of psychoanalytic investigation, since the early workers first inquired into the birth trauma, suggests that pre-natal influence is a subject which it is undesirable to dismiss completely as so much superstitious rot. Besides such undoubted medical matters as the transmission of infection by way of the placenta from maternal to fetal bloodstream, investigators have found reason at least to suspect that the unborn is capable of certain affects and that undesirable reaction-patterns of a type which later contribute to emotional difficulties may be initiated pre-natally. Some of the current theories in this regard can probably be dismissed immediately, but there seems to be a nucleus, however small, of irón fact in the midst of imaginative nebulosity. We know already that the unconscious attitude of the mother in welcoming or rejecting the child is of the greatest import to the infant's future emotional welfare. It may be that the mental state of the expectant mother will prove to be an even more important field than we already recognize for the application of preventive psychiatry.

This sort of discussion is more of an airplane reconnaisance into the vast unexplored than an attempt at a comprehensive view or even a crude map of it. Until we have developed a technique and a rationale, we can hardly forecast the areas in which our activities will lie, or the problems we shall encounter. We think this is a practicable procedure and not without scientific precedent. The pioneers of internal medicine, for example, started with a body of clinical observations made with crude instruments, a primitive and unsystematized pharmocopeia, and a body of unorganized information ranging from household remedies to practices based on sympathetic magic. From this point of view, the first problem of preventive psychiatry is to recruit the body of students and investigators who we hope will become the sanitary engineers of this public health project.

We think, first of all, that we must enlist the scientific personnel who come to our institutions for training and experience—clinical psychologists and social workers. We must endeavor to widen the understanding of those who come as theological interns, and to arouse sustained interest in our visiting college psychology classes. We think we must interest our improved and recovered patients—particularly our neurotic patients, who are treated more often in private practice than in hospital. We can expect sympathetic interest from virtually all of them, and genuine insight from more than a few. We think that even most psychotics who are well enough for discharge are also well enough to apply at least minor improvements in attitude toward mental prophylaxis at home or in home neighborhoods. As for others, the professional people who should be the first consideration, the role of our nurses is very probably both of greatest and most immediate concern.

Of all the people concerned with medicine, more nurses come in contact with families than do any others. Their contacts with patients, whether at home or hospitalized, are far more intimate than are those of physicians. And they are longer lasting. We think the nurse can play a major part in the inculcating generally of principles of preventive psychiatry. We would advise no nurse —as St. Paul did Timothy—to be instant in season, out of season. And we would not recommend that she "reprove, rebuke, exhort." However justified as advice to the apostles, it is poor modern psychology. But there is example, as well as precept; and there are less than blunt ways of conveying precept. Many of the great body of nurses of today are graduates of our mental hospitals; all but a few of the others have had affiliate training or other instruction in psychiatry. Their opportunities for disseminating the principles of psychiatric preventive medicine are by no means confined to the hospital and the sick room; their relatives, neighbors and acquaintances know them as nurses—as professionals concerned with public health. Their advice or opinions, as a matter of fact, may often be accepted with less resistance than the opinions of psychiatrists themselves. For in the minds of many members of our public, nurses are from an understandable and respectable profession, whereas psychiatrists are still regarded as peculiar people, assumed to be ignorant of the normal mind and doubtfully competent even as "nut doctors."

We think we should mention here that psychiatric contacts are less satisfactory than might well be desired with the professional class which should supply the bulk of our mental sanitary engineers—our schoolteachers. At this point, we should make the usual formal bow, and a most sincere one, to teachers as members of a devoted and selfless profession, dedicated as a group and for the most part as individuals, to the upbuilding of human confidence and human happiness. But we should note, too, that we have so developed our society as to make of our teachers a partially ineffectual and frustrated class, often compelled by their own necessities to teach ineffectuality and frustration to our children. The problem is one for society as a whole and is far too comprehensive for more than mention here; it is a problem which psychiatry can well help define but which psychiatry at present is helpless to cope with. The teacher is, however, particularly in the lower grades, the most important parent-surrogate an individual is likely to encounter in life. We know that emotionally immature and frustrated parents are quite apt to pass along those attitudes to their children; we cannot reasonably expect emotionally immature and frustrated parent-surrogates not to do likewise. We think, pending improvement in the attitudes and reactions of society as a whole toward the teaching profession, that psychiatry would do well to extend what help it can to the building up of mature and understanding personalities among our teachers. Closer acquaintanceship between teachers and student teachers and our own specialists of the human mind should be of considerable help to teachers of our first-graders and an aid not to be despised by teachers of our professional students. We suggest that we invite and welcome closer contacts between our own institutions and our teachers' colleges. We suggest—particularly since our mental hospitals could do with more educational therapy—that we study the practicability of programs for teacher-interns, and the possible advantage of inviting selected teachers to seminars or staff meetings.

Whatever our professional schools and professional differences of opinion, we think most psychiatrists would agree that the task of preventive psychiatry is, first, to adjust our children, second, to adjust their elders, to the world in which they live. There is no short, broad, imperial highway to such adjustment. Earnest theologians, social scientists, engineers, political reformers, econ-

omists, fanatics and cranks—to mention others than psychiatrists —have sought short cuts in vain. The task is immensely complicated and is becoming daily more complicated as life itself continues to increase in complexities. The need and the extent of the problem are fully recognized by the mental hygiene movement. But the preventive problem is only one of numerous tasks in the mental hygiene field; and, for most mental hygienists, it is not the most pressing. Preventive psychiatry, like other preventive medicine, must derive ultimately from the medical practitioner himself. It is the task of the psychiatric practitioner, and we think a relatively neglected one, to recruit, organize and send forth the corps of mental sanitary engineers who will meet the problems of mental ill-health and combat them.

The outline of the problem here is far from complete and far from comprehensive. We have not touched at all, for example, on the roles in a preventive program of such groups as the Boy Scouts, or of the juvenile courts, or of social agencies. Our aim, primarily, is to impress on the psychiatrist himself that his role in prevention is primary, and that he might play it better than he has been doing. The distant goal is not only a happier world for our children but a world in which consideration of such eventualities as mass emotional disorder, national fanaticism or preventive war will be a fantastic impossibility.

THE EDITOR'S SCHNOZZLE

We have often heard of a person biting his nose off to spite his face, which, besides being a performance of interesting psychiatric implications, would be a practically unparalleled feat if it could be accomplished. We are now going to see if we can accomplish it.

Like any ordinary pulp fiction magazine, a scientific journal is dependent on its contributors. Good editing, good format and good printing are no warranty of a good publication. Good (or bad) editorials are an expression of an editor's intent, not an ordinary function of magazine structure. In any journal except the strictly polemic, its contributions are its distinctive feature, as pronounced and recognizable marks of its individuality as Cyrano's immortal beak or Durante's world-famous "schnozzle." Speaking first for ourselves, and second—we rather more than suspect—for other scientific editors, we are not entirely happy about the "schnozzle" of present-day scientific journalism. We are weary, too, at times, of applying ordinary cosmetics to it in the way of editorial attention, however intensive. We think that something considerably more drastic is indicated; and if our capacity for contortion proves inadequate for actually biting off our nose, there should be good exercise for the jaw, besides some sound, sadistic satisfaction, in having a good chew at it.

To begin with, we think few editors would find it difficult to endure somewhat greater scientific responsibility on the part of their contributors. We do not mean scientific integrity; we think there are exceedingly few among us who deliberately report false or distorted results, who consciously present misleading statistics, or who make a conscious practice of quoting out of context. If some workers, through superior training or better-balanced emotional organization, do better jobs than others, there is no reason to impugn the good intent and honest effort of those others. What we do feel is that far too many workers, who approach their assignments with as little bias as emotional factors permit, who do their jobs painstakingly and attempt to judge their results meticulously, fail altogether to report them responsibly. We do not feel that this, in general, is a failure in integrity, though it may be in exceptional instances. A character defect as widespread as this fault would be too great a strain on belief; we believe the fault is

in training, in lack of adequate training in the methods and importance—particularly in the importance—of a specific scientific technique.

We stress, in graduate, postgraduate and in-service scientific training, the utmost scruple in procedure and observation. If the necessity for equal scruple in reporting observations is stressed, it is apparent that it either is not stressed enough, or that the teaching method is as ill-adapted (to express a highly personal opinion) as some modern methods of teaching children to read. We wonder whether two rather important matters are being appreciated sufficiently: First, if present scientific work is to have the slightest value for future scientific work, its results must be communicable with clarity and exactness to other scientists than the workers; second, the writing of a scientific communication with clarity and exactness is no instinctual process; it is something to be learned, often painfully and never easily; it calls for the mastery of a specific technique. And when, in this connection, we mention the lack of sufficient scientific responsibility, we think the fault is less the individual's than of the scientific-teaching process. The remedy for today's scientific workers, however, is not in deploring teaching methods, but in making up, individually, for deficiencies themselves. We wish here that more scientists in our own specialty would make individual attempts to remedy such deficiencies.

Let us dispose at the outset of the papers which never should be published or presented for publication. We have in mind the paper written to fulfill some specific requirement and with nothing new or significant to present. There are often legitimate reasons for writing such a paper; a paper may be required for a membership in some scientific group, for a diploma, for an advanced degree, or for completion of a course of training. But unless such a paper contributes something to theory or technique, to clinical practice or research, there is no excuse for publishing it, however good the reason for writing it may be. Professional ethics require that a physician keep himself informed of the general progress of medicine and the particular progress of his specialty. The task is a fantastic demand if we, as scientific editors, bury the significant reports we publish beneath a dead weight of the routine less-than-mediocre. As medical people as well as editors, it might be well for us to remember that it is much easier to bury than to ex-

hume. Unless we ourselves assume our proper responsibilities, we are asking our readers to hunt for buried centimes with bulldozers.

This problem has had some official recognition. The American College of Physicians, for long, set, as a membership requirement, the writing and publishing of a medical paper. It now permits a candidate to submit a thesis, in lieu of publication. The procedure certainly serves all the original purpose. One can as well prove ability and demonstrate a background of good training by an adequate thesis on an old subject as to hunt hopelessly and fumble aimlessly in a futile search for a subject new enough for results to be worth formal publication. And intelligent aspirants (of whom there are large numbers) will be relieved of the thankless necessity of adding to a published literature they consider already too extensive to review adequately.

There is another class of papers which has no reasonable claim to publication. These are the papers in which substantial bias exists on the part of the authors. It is extremely exceptional when a fanatic submits an article supporting his views to which a non-fanatical editor should give serious consideration. It is even more exceptional when a man, who has no interest, or who even has an active disbelief, in what he is reporting, can produce a paper worth publishing. If, for instance, a fanatical psychotherapist, bitterly opposed to all forms of shock treatment, is directed to prepare a paper on shock treatment methods and results, the outcome may be something which is very good indeed for the soul of the recalcitrant psychotherapist, and, so, very worth while of accomplishment; but it is very seldom worth a second's consideration for publication. And we have known of papers prepared, read, and finally submitted for publication (by direction of higher authorities) under precisely those circumstances.

One might turn at this point to work which is in itself worth publishing—work competently done and of a nature to be worth doing—but presented in form unfit for publication. It is work actually done with integrity and responsibility, but is work prepared for publication without proper responsibility. It is an extremely conservative estimate that more than half of the papers worth publishing which come to a scientific editor's desk are in this category.

We think it should be repeated at this point that we are not criticizing the general high quality of American scientific work or the importance of the results often reported. Conceding that a piece of work is worth while, any strictures here are directed at the way it is reported. The ordinary scientific worker seems to have no comprehension either of the difficulty or the importance of good reporting. He is more often than not of the ilk who complain: "Oh, the newspapers; they never get anything right." But the newspaper reporter—untrained in scientific method and scientific accuracy—would be discharged with threats of physical violence for a fraction of the reportorial crimes the scientific reporter commits daily. Aside from the results of painstaking training in accuracy, the newspaper reporter works under the potent economic and social menace of loss of standing, loss of friends and loss of job for major misunderstanding or inaccuracy—the law of libel is powerful motivation for truthfulness and objectivity. The scientific worker, aside from the personal pressure of his own general training in accuracy, is usually menaced by nothing more drastic than a bewildered letter from the editor, asking for explanation and amplification, or at the worst a polite rejection of a paper which—properly presented—is worthy in every respect of publication.

There are certain essentials which a news report and a scientific report share: WHAT is being reported; WHEN it took place; WHERE it took place; WHO is reporting it; and WHO, besides, is concerned; WHY is it being reported, and WHY did it happen in the first place; and, finally, HOW did it happen, anyway? We have often heard jeers at the allegedly unimaginative practice of attempting to answer all these questions in the first sentence or first paragraph of a newspaper article. The principal purpose is to tell the reader the outstanding facts at a glance, and let him determine if he has the time or the interest to read the rest of the article and so inform himself of the details. Precisely the same information is supposed to be included in the summary of a well-prepared scientific paper—and for the same reason; it is to tell the reader the outstanding facts at a glance and let him determine if he has the time or the interest to read the entire paper. There are comparatively few busy practitioners who have the time, aside from the interest, to read all of even a highly-specialized literature. There are also, unfortunately, comparatively few sum-

maries that answer adequately the questions in the mind of such a busy reader; when an editor finds such a summary, he is likely to be filled with warm gratitude toward the contributor, regardless of the merits of his manuscript.

There are certain other characteristics, too, which good scientific writing shares with good non-scientific writing. In all good non-fiction, there should be a pattern of organization. One states a proposition, outlines the procedure to be followed, then takes his steps one by one and systematically. Except in unusual instances, the experienced writer does not scatter his statistical or theoretical material aimlessly about the landscape to be interspersed with comment and theory. He maps a logical plan and proceeds logically from one part to another. He does not, for example, divide his patients into groups "a," "b," "c," "d," and then proceed to describe and discuss groups "d" and "c" before treating of groups "a" and "b."

To present scientific material clearly and logically, the writer needs a plan, just as a builder needs architect's drawings and specifications. A plan is something which even the professional writer —one who engages in writing daily—disregards at his peril, although with long practice, scientific and non-scientific writer alike may follow mental, not written, outlines. For scientific writings, the sort of outline (or table of contents) that one may employ for a term thesis may serve. Or index cards to be arranged and rearranged may meet an individual need even better. For citations taken thus from the writer's primer, we might well apologize—were it not for large numbers of otherwise good manuscripts which not only appear to have been written without plan, but for which plans could hardly be discerned after completion. Like Topsy, these things simply grow; they aren't premeditated; they merely happen—sometimes, unfortunately, obscuring scientific work of merit with a maze of un-co-ordinated maunderings.

One might, perhaps, discuss briefly as a group a number of unrelated matters of presentation. From the editor's chair, it is sometimes difficult to justify some so-called scientific language. No practical editor expects to find scientific papers which are literary gems—after all, he can always read anthologies for poetry and the Bible for prose—but he does have every right to expect writing which is clear and intelligible. He expects, or at least hopes for, case histories, for example, which are presented in sim-

ple English sentences, including the definite and indefinite articles and the verbs, and avoiding the abbreviations of social workers', interns', and ward supervisors' notes. He expects a style which is appropriate for the material presented: general and statistical material reported impersonally and in the third person; anecdote and some types of clinical material in the first.

The modern scientific editor does not expect scientific words to parade in boiled stuffed shirts; between simplicity and pretension, English and Latin, simplicity and English are preferred every time. However, he also does not expect ungrammatical colloquialisms, scientific slang, exaggeration, facetiousness or irony—excepting, of course, in polemical papers, theoretical discussions or essays of certain types, for all of which appropriate allowances are made. It is possible to present many—though certainly not all—scientific subjects in language which is a delight to read and a pleasure to hear; and this QUARTERLY is happy to believe that it has published examples. But the scientific writer is not expected to be a master of rhetoric or even of grammar; it is one of the jobs of the editor to see to such matters. Neither is the present-day scientific writer expected in all cases to be a complete master of English. Many of today's finest scientific contributions are being made by scientists to whom English is not native. All editors today expect to encounter sentences made up of English words in German arrangement, or French arrangement—or perhaps Spanish, Hungarian or Russian. It is the job of the editor to know enough about foreign language structure to recognize and rearrange. The writer has done his part if he writes simply and clearly. And we don't want to hear that he doesn't have the time. From our observation, what he lacks is not the time but the inclination. A man who has the time to do good work has the time to report it properly—if he comprehends the need.

No exposition of editorial paranoia would be complete without mention of statistics. Despite the truism that all science, including psychiatry, must be based on statistics, it is our experience that few writers, fewer readers and few editors really understand statistics. Yet neat little columns of figures are a temptation to all of us, ready to trap the unwary into the mortal sin of not knowing what they are figuring about. We think that, with very few exceptions and for everything but the simplest tables, the writer would confer a great favor on editor, reader and himself

by consulting a statistician as to method and conclusions before himself making laborious use of statistics. For the trained statistician, who knows statistics thoroughly and bears pure affection toward such things as significant differences and the square root of minus one, the temptation is different. The caution here is that few readers of scientific journals share such wholehearted enthusiasm, and that a paper compiled for the love of statistics does not become a readable or important scientific contribution by attaching a paragraph to each table to summarize the statistics.

Similarly, it would please medical editors generally if writers on highly-specialized topics or techniques, or on disciplines other than the journal's own specialty, would temper their technical terms to reader understanding. For example, terms familiar in many surgical specialties, in gastro-enterology, proctology, anatomy, neuropathology, or even internal medicine, may be unfamiliar to psychiatric readers generally, with their meanings by no means self-evident. We do not expect the urologist or the ophthalmologist to understand our own esoteric jargon; we could sometimes do with a little more specificity when it comes to reading theirs. That is, in the case of many terms, we and our readers alike could tolerate explanations and definitions. We could tolerate, too, we think, somewhat greater consistency in the use of terms in the whole range of medical science from anatomy to the pharmacopeia. However mindful we are of the desirability—as taught in elementary English composition classes—of the use of synonyms for variety in writing, we think "hippocampus," "hippocampus major," "Ammon's horn" and "cornu Ammonis" are three terms too many to be used in a single article in reference to a single brain structure. We also find it confusing when a writer on the use of $C_{17}H_{21}NO_4$ can't make up his mind as to whether he is writing about hyoscine or scopolomine; or when a fellow-author administers $C_6H_5.CH_2.CHNH_2.CH_3$ (amphetamine) to his first depressed patient, and $C_6H_5.CH_2.CHNH_2.CH_3$ (benzedrine) to his second one. These things are matters of general usage, common sense and consideration for the reader—not of rigid rules. Usage, common sense and reasonable consideration would all sanction, for example, the use of "schizophrenia" and "schizophrenic" as general synonyms for "dementia præcox" and "dementia præcox patient." And no editor or reader should object to "general paresis" as a universally understood and acceptable term for the cumbersome

but more descriptive official phrase, "syphilitic meningo-encephalitis," although we hold the line firmly against "general paralysis." The contributor who will study the literature of his specialty before attempting to write it can usually find reliable guides.

It would also seem appropriate to call attention briefly here to the fact that observance of the conventional rules for manuscript presentation—while not strictly a matter of good scientific method—is a courtesy much appreciated by editors. It has been many years, of course, since handwritten reports were acceptable; but a surprising number of authors—many of whom know better but are "forgetful"—still submit single-spaced copy. All writers familiar with editing know that such copy is difficult, if not impossible, to edit—and all articles require at least a certain amount of editing. Many, too, submit manuscripts on onion-skin or other paper on which editing is difficult or on which our printers in particular find the typing hard to read. We think, too, the matter of uniformity in style might be noted. "Toward" and "towards," for instance, should not be jumbled in the same manuscript. To obtain uniformity, all publications have style rules; and this QUARTERLY will be glad to supply brief notes on its own rules on request. But no editor expects that all the papers he considers will have been written with his journal solely in mind. What he does expect is consistent treatment so that his editing for conformity to his own style can follow a pattern.

We think finally that most scientific writers—beginners, experts, good ones, bad ones—could use a lecture on the subject of documentation. The writer who documents his paper completely or accurately is so exceptional as to be practically mythological. Many a writer's reference list includes titles not referred to in the text—or vice versa. His text numbers do not correspond to his list numbers. Some of his authors are listed by last names only, some by full names; some of his publications are listed by month and year, others only by issue and volume number. Reference list abbreviations are cryptic, proper names and words in titles misspelled, foreign words sometimes illegible.

We suspect there is a general practice of saying to the inexperienced junior author or the stenographer: "Here, you list the references." And we suspect there would be fewer reference list errors if authors would read over manuscripts before mailing them. When a reference list is compiled, the author has the material at

hand to make it accurate—or he has no business using it. He can check that material with comparative ease. An editor cannot. An editor can very easily spend two days or more on a list which its author could have verified and corrected in an hour; and then the editor may not succeed in correcting it unless he has, like few of us, the Library of Congress at his disposal.

While the author is checking references, he might very well also check the accuracy of stenographic transcription. "Effect" for "affect" is one of hundreds of common errors in psychiatric dictation. We frequently note such things as "evolution" for "involution"; and we are saving for our editorial treasury of errors the transcription, "interviews," for "antabuse"—in a context where "interviews" almost made sense too. And concerning authors' re-reading of manuscripts in general, many inexperienced writers need telling—and many more experienced ones need reminding—that the place to make corrections, revise phraseology, or add or delete material, is in the manuscript, not in the proofs. Editing in proof involves loss of time, invites new typographical errors, requires expensive resetting and correcting for which the author himself may be charged, and causes possible delay in publication; it hits a scientific journal where it hurts the worst—by increasing the costs of publication. And something like a pinnacle of this editorial woe is reached when an author, as happens, makes proof corrections in an already-engraved illustration.

We might, at this point, do well to remind everybody that this little essay is simply an expression of professional opinion—one without, as the psychoanalysts put it, any animus, hostility or condemnation whatever. We might also admit that we have been, and are, guilty from time to time of some or all of the crimes against science which we have criticized; and we could add that an editor setting out full sail to make an error can do a blazing, destructive job beside which an ordinary writing error is insignificant. We wish emphatically to disclaim here any "holier-than-thou" attitude. Anybody who thinks we cannot recognize our own capacity for making mistakes is invited to look at the *"errata"* notice in this issue of THE QUARTERLY. We should add, in self-defense, that when we list *errata* we do not assign responsibility. Sometimes the errors are the editor's; sometimes the author's—who also sometimes, regrettably, doesn't seem to read his proofs; sometimes they are the printer's and proofreader's; the important point

here is that sometimes they are the editor's. We have not attained perfection ourselves and do not expect it of other people. We have merely endeavored here to deal out blows impersonally and impartially; some of our best friends are guilty of something or other; and we think it is time that their best friends told them.

As for ourselves, we recognized this effort at the start as masochistic, as well as sadistic. We value our writers, we are proud of our good repute for sound, scientific articles; and if anybody gets ideas of reference about this, nobody will be sorrier than we shall be. We expressed, at the beginning, doubts as to the general wisdom of chewing at our editorial nose to spite our editorial face —and we shall be delighted if we escape without calling in a plastic surgeon.

Yet to conclude, scientific writing is a technique, a trade, or an art, in itself—and nobody seems to take the trouble to teach it, or at least to teach it properly and see that the teaching sticks. Science is a co-operative, not an individual, endeavor; writing is the means of communication through which scientific workers co-operate; and we think it is worth more attention than our scientific schools seem to give it. Writers, like doctors, are not born that way, but made. We think intensive courses in scientific writing in our graduate schools and postgraduate training could raise the level of scientific journals materially, not only in writing but in editing. We might, in fact, consider signing up for a refresher course ourselves, if somebody could show us where there is a good one.

BOOK REVIEWS

Dianetics. By L. Ron Hubbard. 435 pages plus glossary and index. Cloth. Hermitage House. New York. 1950. Price $4.00.

It is impossible at this point to say whether Mr. Hubbard's claim of "cures" in *Dianetics* as a result of the application of his "proven scientific facts" is valid. In spite of his rather glib statements to that effect, much of the material presented is not fact, and certainly not scientific. Perhaps someday he will write another book and cite some of the experiments (including his new discoveries in the field of cytology) and clinical investigations which have led, over a period of 25 years, to the promulgation of the theories which make up the sum and substance of dianetics. However, until such a book is written, medicine will have no way of evaluating the author's claims. His offer of proof of "cure" of over 200 patients is no proof at all until we know that he is functioning any differently than the faith healer, the professional hypnotist or perhaps an anachronistic adherent of Coué. A certain percentage of neurotics will respond favorably, if transiently, to suggestion or to the abreacting of some of their unconscious conflictual material. This elementary observation would not even seem to bear repetition except for the fact that these basic facts have been ignored in the author's eagerness to create a new and "fool-proof" therapy of mental illness, while at the same time scorning to acknowledge kinship or obligation to the well-established psychotherapeutic and psychodynamic systems.

This reviewer, like most other psychiatrists who have read the book, could not help but be impressed by the fact that the author, consciously or otherwise, owes much to psychoanalysis in spite of his rejection of all forms of organized psychological and psychiatric thought.

His techniques for sending the patient back over the "time track" are certainly reminiscent of a hodge-podge of hypnosis and free association. Their attempts to recall early childhood memories, particularly the traumatic ones, are obviously the prototypes for the author's retrograde adventures on the "time track." And one is reminded of Rankian "birth trauma" by the "basic-basic engram" of dianetics. In fact, the author has borrowed much from psychiatry, including many of his terms, but has managed to add to the confusion by giving entirely different definitions to all-too-familiar terms.

One wonders about the background of the individuals who have made and checked the diagnoses in the cases treated. Also, what sort of follow-up was used and for how long? Certainly until these data are available the author cannot expect to be taken seriously by the psychiatry which he

rejects. We understand that the Dianetics Institute (a research foundation organized for the purpose of teaching as well as developing dianetics) is preparing statistical material as a result of numerous requests for the same. It appears odd that statistics should be offered in retrospect of "proven scientific fact." Proven by whom, to whom, and how, is a question that Mr. Hubbard's primary object, the intelligent layman, is surely entitled to ask. At the risk of belaboring a point (a well-taken one, we believe), what about the author's background in psychiatry, psychology, sociology, anthropology, biology, genetics and other allied fields which he uses and abuses in his dissertation?

We have been told that Mr. Hubbard is or was a science fiction writer. Certainly this should not detract from his thesis, since some very reputable scientists double in brass as authors of science fiction. Yet, so much of dianetics reminds this reviewer of the science fiction period of his early 'teens that the impression gained was that perhaps the author tended to over-dramatize the reporting of some of his therapeutic sessions.

The author claims complete "cure," no failures, in all his cases. And he prepares his readers for the inevitable barrage of adverse criticism by implying that those who disagree with dianetics are themselves in need of dianetic therapy. Even here our author borrows a page from some of our more rigid analysts who reject criticism as emanating from the unconscious emotional conflicts of the critic.

The foundation of dianetics is the "engram" which is defined as "any moment of greater or lesser 'unconsciousness' on the part of the analytical mind which permits the reactive mind to record; the total content of that moment with all perceptics." The analytic mind is defined as that mind which computes the "'I' and his consciousness." Reactive mind is "the cellular level mind" which is not "unconscious" but is always conscious—the hidden mind, hitherto unknown. And finally, "perceptic" is "any sense message such as a sight, sound, smell, etc." The author believes that during any period of unconsciousness accompanied or induced by pain, the reactive mind mechanically records all that is said. The "basic-basic" is the engram recorded by the fertilized ovum. Anything said in the "hearing" of the engramatic zygote is recorded and becomes the beginning of a long chain of engrams which may be incurred both pre- and post-natally. They remain dormant until "keyed-in." This apparently means until some event in the individual's life coincides in content or connotation with the engrams. Often the patient cannot be cleared (cured) until the basic-basic is reached. Although to call the concept of the recording zygote far-fetched and lacking proof is an understatement, the claim that the zygote actually hears the words spoken at the time of recording defies qualification. The only conclusion available is that the author has perhaps become far more preoccupied than he should be with

the microcosmic speculation originally undertaken for the edification and/or amusement of his less critical adolescent following.

According to the author much trauma, and therefore engram recording, takes place when the father beats the pregnant mother; when the father (in the hearing of the fertilized ovum, of course) rejects the child while engaging in coitus; when the mother uses knitting needles (apparently a favorite substitute for a curette among the laity) to attempt criminal abortion, or even when coitus occurs during pregnancy without paternal rejection of the zygote. But an engram can occur at any time, and the author urges therefore that when an injured woman is being given succor, it be done in absolute silence, lest she be pregnant and an engram be recorded by the fetus. One cannot help but speculate upon the all-too-frequent presence of the ominous, threatening father figure as the source of trauma. Can all this perhaps be an acting out of hostility toward an authority figure—in this case psychiatry? In fact, much is made in the introduction of the distinction between "Authority" and "authority," the latter being the source of true knowledge.

The author indulges in setting some dangerous precedents when he states that a background of medicine, psychiatry or psychology is not necessary to practise dianetics. This may be so, but if "dianeticians" are to treat those who are emotionally ill, we are going to witness unnecessary and avoidable tragedy caused by the well-meant but clumsy, bungling efforts of friends and family of those who properly deserve expert psychiatric aid. And this does not include the less well-meant efforts of the charlatan and the lunatic-fringe faddist. Probably the author in his commendable enthusiasm did not foresee these undesirable effects, but he has paved the way for them by declaring that a reading and understanding of the book would enable the intelligent layman to treat emotional ills. And indeed in a short time, one infers, laymen can become far more skilled than any practitioner of psychiatry.

Probably the chief defect of the book is that it completely ignores the emotional organization and development of man, and confines its interest to the mechanical recording of the "reactive mind" and to whatever incident "keys in" the engrams. The description of therapy abounds in such terms as "file clerk" (a part of the mind), "demon-circuits," "bouncer," "visio," "sonic," etc. These are all reflections of the author's mechanical concept of the mind. In a typical lay fashion he yearns for the "one-shot clear," i. e., a cure in one therapeutic session, just like putting in a new spark plug or changing the generator. This mechanization of the "mind" is unjustified and unwarranted. The continuing mind-body dichotomy perpetuated by many psychiatrists is undoubtedly the fountain-head of all the bizarre absurdities in this book.

The author very condescendingly promises that dianetics will not seek punitive legislation against physicians who have done so much "harm" with shock therapy and lobotomy. At the same time he assures his future flock that there is no legislation which covers or affects dianetics since dianetics was never thought of before.

From a more literary standpoint, the book is over-long, excessively repetitious, exceedingly vague at times, and often reminiscent of a double-talking comedian aping a pompous psychiatrist. It is replete with numerous neologisms as well as with familiar scientific terms given new meanings. The appended glossary is meager and inadequate. And the inclusion in the appendix—without comment—of an excerpt from ***The Story of Philosophy*** by Will Durant is unnecessarily misleading; readers may somehow get the impression that Will Durant is in some manner associated with dianetics.

All told, this is a pretty bad book. It will be bought (if not read) by a great many hopeful, if disappointed, people, as witness the fact that it is on the best-seller list.

Principles of Intensive Psychotherapy. By FRIEDA FROMM-REICHMANN, M. D. 224 pages. Cloth. University of Chicago Press. Chicago. 1950. Price $3.75.

The author is an adherent of Harry Stack Sullivan; readers familiar with Sullivan's *Conceptions of Modern Psychiatry* (extensively reviewed in this QUARTERLY, Vol. 21, No. 3, pp. 494-499, 1947) will find little new in Fromm-Reichmann's new book. The terminology is Sullivan's; his two Shibboleths of "interpersonal relations" and of "security and satisfaction" as basic life-aims, are maintained, just as are his neologisms ("interpersonal relations in terms of power manipulations," "significant adults" for parents, "parataxic dissociations" for transference, "security operations," etc). Still, the new book represents "Sullivan plus."

What this "plus" consists of is difficult to define, perhaps a few drops more of watered down "old-fashioned" psychoanalytic concepts. This watering down is already visible in the quite extensive index: Such negligible terms as libido, super-ego, oral-anal-phallic eroticism, psychic masochism, unconscious guilt, pre-Oedipal phase, are not included.

Then one finds that the author refers to herself and colleagues of her school of thinking as psychoanalytic psychotherapists; the result for the reader is a slightly Babelian confusion of language; fortunately this is resolved on page 99.

"Freud has emphasized . . . that the term 'psychoanalysis' may be applied to every type of psychotherapy which recognizes the problems of transference and resistance, the basic importance of the 'Unconscious' and

of the early developmental history . . . But, in line with the previously mentioned revision of the psychosexual concept of the developmental history, we find this love by no means to be always sexual in nature. Consequently, this hatred is seldom of the nature of sexual rivalry. In my experience the wish for closeness and tenderness with the beloved parent and the envious resentment about the authoritative power of the hated one, both without recognizable sexual roots, constitute a more frequent finding in childhood histories of healthy, neurotic, and psychotic people than do their sexual Oedipal entanglements with the parents of their childhood." Of course, Freud never intended that his term "psychoanalysis" be applied to a technique which negates the Oedipus complex and libido-theory. To increase the irony, the sentence quoted by the author is included in Freud's *The History of the Psychoanalytic Movement* which contains precise refutations of Adler and Jung who did exactly that.

In this twilight of eclecticism, based on three-fourths rejection and infinitesimal acceptance of Freudian concepts, we find ideas which have no connection with Freud's basic teachings. To exemplify: Libidinous contents in the unconscious are mostly negated; neurotic symptoms are mainly "expressions of the patient's anxiety and defense against it" (p. 22), thus the "substitute gratification" of Freud's concept is excluded; neurotics are defined as "eternal adolescents who refuse to grow up and who therefore try to maintain the defiant attitude of teen-agers toward that which represents to them the demands of the adults, against whom they rebel" (p. 33). Thus the unconscious libidinous contents of neurosis are thrown out of the window; the Oedipus complex is negated; Freud's dream theory is partly rejected—"the concept of the universal character of dreams as disguised expression of fulfilment of unacceptable wishes is open to controversy and revision" (p. 170). Finally, Freud's ideas on aggression are rejected ("I am not in agreement with the teaching of classical analysis, according to which people are born to be hostile and aggressive" (p. 22).

Every psychiatrist is familiar with wide divergencies of opinions concerning Freud's basic concepts. This being the case, there is no reason—at least no scientific reason—to self-adduce the term "psychoanalytic" to a form of psychotherapy which, according to Freudian principles, just isn't Freudian. The question remains: What is the substratum of the therapy advocated in this book, and what is the theoretical foundation? We read with some surprise that "people of this Western culture do not seem to find it too difficult to talk about sexual attachment . . . many of us are reluctant, if not afraid, to speak about the friendly, tender, asexually loving aspects of our interpersonal relationship" (p. 99). In short, repressed hatred and tenderness of asexual nature seem the great troublemakers. Indeed, the whole material presented is based on repressed ag-

gression. The preponderance of weight on aggression exclusively brings the whole concept in the vicinity of Adlerian theories, although this is not mentioned. Hence the book makes the impression of enormous and unjustified simplification of the psychic apparatus.

The impression of simplification increases when aggression is without exception taken at face value; the idea that masochistic attachments may be warded off with spurious, would-be aggression, is unknown to the author; at least, she does not apply it in the material presented. One wonders whether interpersonal relations are never masochistic. The word is used only once; in advocating admission of the analyst's failures of technique to the patient, we read that it is "useful to comment on his error in a matter-of-fact and nonmasochistic manner" (p. 20). Without being flippant, one could ask whether psychic masochism, in this view, is the psychiatrist's prerogative.

The book is written in a sympathetic manner, the language precise. It is a pity that the oversimplification of the approach makes it of little value for the psychiatrist, although it contains potentially interesting material, especially in connection with the psychotherapy of psychotics.

Sex in Psychoanalysis. By SANDOR FERENCZI. Translated by Ernest Jones, M. D. Foreword by Clara Thompson, M. D. 338 pages. Cloth. Basic Books. New York. 1950. Price $3.50.

Sex in Psychoanalysis. By SANDOR FERENCZI. Translated by Ernest Jones, M. D. 338 pages. Cloth. Robert Brunner. New York. 1950. Price $3.50.

Two publishers, Basic Books, and Robert Brunner, present, by what this reviewer understands to be coincidence, two new editions of an important psychoanalytic classic. This work by Ferenczi, translated years ago by Ernest Jones, was first entitled *Contributions to Psychoanalysis*, a far better descriptive title than the present one, but one which obviously called for a change. The collection contains the paper, "A Little Chanticleer," on Ferenczi's famous child-subject, Little Árpád; in addition to papers on impotence, introjection and transference, dreams, obscene words, symptom-construction and other subjects of considerable general interest. These essays belong in every library of introductory books on this medical specialty.

The edition by Basic Books contains, in addition to Dr. Jones' original preface, a brief introduction by Clara Thompson, M. D. which should be of material value to the student. Both editions of the essays are reproductions of the original translation. That of Basic Books, the publishers state, was made from the original plates, while Brunner's edition appears to be a reproduction by the offset method. The Basic Books volume is

considerably the better in clearness of type and general format; and its publishers note that they have corrected typographical errors which appeared in the original.

Practical and Theoretical Aspects of Psychoanalysis. By LAWRENCE S. KUBIE, M. D. 252 pages. Cloth. International Universities Press. New York. 1950. Price $4.00.

The first edition of Dr. Kubie's *Practical Aspects of Psychoanalysis*, published in 1935, rendered a great service to people in analysis, their relatives and friends, and to those about to undertake personal analyses. In the 15 years since the publication of that valuable little book, interest in psychoanalysis has expanded so greatly that one might wonder about the necessity to explain to anyone today just what psychoanalysis is. The things, however, which make this absolutely necessary are: the distortions which have resulted from over-popularization, the divergent anti-Freudian schools whose followers insist on calling themselves psychoanalysts, and the actual changes and advances in the practice and theory of psychoanalysis in the last decade.

The current book is truly a new book. It is an accurately honest and intimate account of what psychoanalysis is and what it is not. It defines psychoanalysis and tells how it differs from other forms of psychotherapy today. It explains such technical details as the couch, the daily sessions, the transference, dream analysis, etc., in a way to dispel the mystery which has contributed to current psychiatric-cartoon humor. The cost of psychoanalysis is similarly scientifically dealt with by an accurate statistical study of costs in various places so that the reader may know exactly where he stands.

In the course of the discussion of these factors, Kubie brings into the book a number of subjects of grave theoretical import such as: the role of insight in psychotherapy, the relations of psychoanalysis to moral responsibility, to religion, and to social, economic, and political change. The chapter on the concept of normality and the neurotic process is a masterpiece of exposition. There is an excellent section on training and organization which attempts to tell what it takes to be a psychoanalyst. This section discusses the non-Freudian "analyst" as well as the non-medical psychoanalyst. Section V, the last section, more than adequately presents in less than 25 pages the controversies and divergences from psychoanalysis. As in the other sections, Kubie is scientific, accurate, and dispassionate, presenting clearly how real contributions to psychoanalysis have been and continue to be incorporated into the main stream, and indicating the inutility of popular drum-beating in attempting to make any minor tributary take the place of the main body of psychoanalysis.

This reviewer finds very little to criticize in Kubie's fine book. There may be a slight tendency to undervaluate other than psychoanalytic forms of psychotherapy, but it is doubtful if Kubie meant to imply that only formal psychoanalysis can be effective. There is no psychiatrist practising today who has not been influenced for the better, either consciously or unconsciously, by (Freudian) psychoanalysis. For all psychiatrists, this book is a "must." Psychoanalysts will find little that is new, but the material is beautifully organized and summarized. For all others who want to know more about the meaning of psychoanalysis in both its practical and theoretical aspects, the book is recommended without reservation. For patients in analysis, for referring physicians, for prospective patients and their friends and relatives, this new book is even more valuable than its predecessor.

The Mask of Sanity. Second edition. By HERVEY CLECKLEY. 569 pages including index. Cloth. Mosby. St. Louis. 1950. Price $6.50.

This is an enlarged, revised and re-written second edition of Hervey Cleckley's stimulating and exciting work on the psychopath. The author explains that increased clinical experience and wider acquaintance with the literature has led to modification of his ideas and to the necessity for a different presentation of them.

The present volume of 569 pages compares with 298 in the first edition. To the extensive footnotes of the first edition, he has added a reference list of 226 items. A change in the point of view may be indicated by the subtitle which read originally "An Attempt to Re-Interpret the So-Called Psychopathic Personality" and now reads "An Attempt to Clarify Some Issues about the So-Called Psychopathic Personality." Cleckley's original work leaned heavily on the school of general semantics to interpret the phenomenon of psychopathic personality; and, in the introduction to the present work, he again makes his acknowledgments to Korzybski. The book's principal thesis remains unchanged: that the psychopath should be considered a medical and psychiatric problem and that modifications in medico-legal attitudes are imperative to establish his degree of incompetency to manage his own affairs and provide for his supervision. Granting that we cannot flood our existing hospitals with psychopaths not now diagnosed psychotic, Cleckley stoutly maintains "that a multitude of patients with the psychopath's disorder are in greater need of hospitalization and medical supervision than a large percentage of those now in institutions for the psychotic and for the mentally defective." He concludes: "In the United States, provision has been made for the care of hundreds of thousands of patients with psychiatric disorder. If there is among all

these facilities accommodation provided for one psychopath, I would be grateful for information leading to its discovery."

This second edition, like the first one, is a basic work for the study of psychopathy. It provides a very useful bibliography for further study. In addition, it is well organized and brilliantly written. No responsible reviewer can recommend a serious scientific work simply as entertaining reading, but Cleckley contrives to present scientific material in entertaining form. As was the case with the first edition, the reader of Cleckley's current work is likely to find himself fascinated as well as informed.

Trial of Jessie M'Lachlan. (Second edition) William Roughead, editor. 402 pages. Cloth. William Hodge and Co. Ltd. London. (British Book Centre, New York.) 1950. Price $3.50.

Trial of Oscar Slater. (Fourth edition.) William Roughead, editor. 338 pages. Cloth. William Hodge and Co. Ltd. London. (British Book Centre, New York.) 1950. Price $3.50.

Trial of Hawley Harvey Crippen. (Second edition.) Filson Young, editor. 211 pages. Cloth. William Hodge and Co. Ltd. London. (British Book Centre, New York.) 1950. Price $3.50.

Trial of Alma Victoria Rattenbury and George Percy Stoner. F. Tennyson Jesse, editor. 298 pages. Cloth. William Hodge and Co. Ltd. London. (British Book Centre, New York.) 1950. Price $3.50.

Trial of Buck Ruxton. R. H. Blundell and G. H. Wilson, editors. 457 pages. Cloth. William Hodge and Co. Ltd. London. (British Book Centre, New York.) 1950. Price $3.50.

Trials of Frederick Nodder. Winifred Duke, editor. 242 pages. Cloth. William Hodge and Co. Ltd. London. (British Book Centre, New York.) 1950. Price $3.50.

The notable British Trial Series starts with Mary, Queen of Scots, Guy Fawkes and King Charles I and descends from the affairs of royalty to modern psychopathology and small-time treason. The six volumes reviewed here concern six cases, three which rated in their day as *causes célèbres*, on this side of the Atlantic as well as the other.

The trial of Jessie M'Lachlan appears in a second edition. It was one of the most hotly debated murder cases in either British or American history. Jessie M'Lachlan was convicted of the murder in Glasgow in 1862 of her fellow-servant, Jessie M'Pherson, in the home of John Fleming and

his respectable family. The murder excited the public in extraordinary fashion and divided the press into bitterly warring factions. There were many who believed then, and many who think now, that Jessie M'Pherson was murdered, not by Jessie M'Lachlan, but by elderly James Fleming, the father of the householder for whom she worked. And however this may be, there are psychopathological factors which tend to favor the theory. Jessie M'Lachlan, nevertheless, was tried, sentenced to death, conditionally pardoned to life imprisonment, and finally released. James Fleming was never tried or even arrested. The British home secretary once declared, in connection with this case, that under Scottish law, "a witness in a criminal trial cannot afterwards be subjected to a criminal prosecution in respect of the matter of such trial." Fleming and Jessie M'Lachlan are long since dead with the issue unsettled unless, as the editor suggests, it will be settled at the last Great Assizes. This case has remained for nearly a century not only one of the most fascinating in criminal jurisprudence but one of the most interesting from a psychological point of view. Its appearance in second edition is greatly to be welcomed.

The trial of Oscar Slater took place in 1908. For a time it attracted almost as much international attention—and for the same reason—as the Dreyfus case. Slater, convicted of the murder of an 80-year-old Glasgow woman, suffered as great a miscarriage of justice as did Dreyfus. He was released 20 years later through the unceasing efforts of friends and co-religionists and the active interest of Sir Arthur Conan Doyle and others in his behalf. He was finally cleared and to some extent compensated, although the government steadfastly refused to defray the expenses borne by his supporters. In the end, says the editor, "Sir Arthur, having called the tune, had, as appears, to pay the piper." Slater's conviction, obtained on evidence of identity alone and totally without other evidence or circumstances which might indicate guilt, is as extraordinarily a prejudiced performance as could be found readily in legal history. It is difficult to believe that it occurred under British justice. The report, as given in this volume, should be of particular value to those interested in the psychology of motivation of criminal prosecution.

The trial of Hawley Harvey Crippen in 1910 was almost as great a sensation in America as the Thaw case. Crippen was convicted and executed for the murder of his wife in London. He was, however, an American; his wife was an American; and Ethel Le Neve, the girl for whom the murder was supposed to have been committed, was a Canadian. The trial has fascinated the medico-legal mind ever since. Crippen was a medical doctor, practising as a dentist. Mrs. Crippen (Belle Elmore) died of a five-grain dose of hyoscine. There has been much speculation since as to whether Crippen intended to kill her or did so accidentally while administering the drug for another purpose. His trial was made extremely sensational by

dismemberment and attempted concealment of the body and later by his arrest at sea accompanied by Ethel Le Neve disguised as a boy. The girl incidentally was acquitted.

The murder for which Alma Rattenbury and George Stoner were tried was that of Mrs. Rattenbury's aged husband. It occurred in 1935. A rather better than good-looking woman of 38, Mrs. Rattenbury had sought a handy man with Boy Scout training and had found 18-year-old Stoner. She promptly seduced him and, as a result of the ensuing marital triangle, the not over-bright Stoner killed his rival. Stoner was convicted and reprieved. Mrs. Rattenbury was acquitted but her character was so thoroughly besmirched—the court in which she was tried apparently having been, in the words of the editor, a "court of morals" as well as a court of law—that she committed suicide. She had the desperation to stab herself six times. The record of this case provides such material for study of emotions as is not commonly found in a trial.

The trial of Buck Ruxton is another of considerable medico-legal interest. Buck Ruxton was a medical man, a native of India, in practice in Lancaster, England. He was executed for the murder of the woman who lived with him as his wife and whom he killed with her maidservant. Ruxton partially dissected and concealed the bodies. During the trial medical evidence concerning them established interesting precedents. The psychopathology of the case does not appear to be of great interest. Ruxton seems to have killed Mrs. Ruxton in a fit of rage and to have killed the servant to keep her quiet.

The Frederick Nodder case is the highly unpleasant record of the rape and murder of a little girl by a sexual psychopath who was boarding in her home in Newark, England. The case is extraordinary in that the prisoner was first convicted and sentenced for abduction before the child's body was found. After its discovery he was tried, convicted and executed for murder. Nodder's crime was committed in January 1937. He was convicted and sentenced for abduction in March. He was tried for murder in November. His appeal from the guilty verdict was heard and dismissed in December, and he was executed on December 30 of that same year. Besides the speed of British justice, mental specialists will find the defense well worth study as a contrast to the type of defense commonly met in this country in a crime of this sort.

Fundamentals of Adlerian Psychology. By RUDOLF DREIKURS, M. D. 112 pages. Cloth. Greenberg: Publisher. New York. 1950. Price $2.00.

"This book, previously published in several European languages, until now has not been available to the American public. It was written in German in 1933, based on a lecture course for physicians in the Academic

Society for Medical Psychology in Vienna in 1932. Its purpose was, and is, to give the student an opportunity to acquaint himself briefly with Adlerian Psychology," the author states in his introduction, which follows a foreword written by Dr. Adler in 1933.

To say that this book contains only psychological ideas expressed by Dr. Alfred Adler would be untrue. It contains, mainly, Dr. Dreikurs' ideas; ideas which follow the principles of Adlerian psychology; ideas relative to child psychology, to experiences producing feelings of inferiority and personality deviations, to the types of psychotherapeutic methods recommended.

To say that the ideas, about which Dr. Dreikurs writes, are new would be incorrect, but his style of writing makes pleasant and easy reading.

Psychiatric Sections in General Hospitals. By PAUL HAUN, M. D. 80 pages. Cloth. Country Life Press. Garden City, N. Y. 1950. Price $4.00.

This timely book written by a psychiatrist (Dr. Haun is assistant professor of psychiatry at Georgetown Medical School) discusses the thinking which must go into the planning of psychiatric facilities in general hospitals.

The book is oriented to the architect as well as to the general hospital executive and board members planning psychiatric units. It presents many practical considerations that must receive recognition and offers the architect designing psychiatric units in general hospitals a method of approach to the problem.

The author states that the architect must be given a clear definition of the proposed use of the unit, the type of patient to be admitted and the varieties of service to be rendered. He must be advised as to the relationships that exist between this unit and other functioning units of the hospital. The fundamental requirements of security for mental patients must be met, but a "psychiatric unit which sacrifices therapy for security should be operated by penal authorities and not by physicians." The architect is urged to work closely with the physicians particularly with reference to space allocations and interrelationships.

As the writer is also chief of the Hospital Construction Unit, Psychiatry and Neurology Division, of the Veterans Administration, a considerable portion of the book is devoted to the planning for psychiatric units in the Veterans Administration general hospital program. A discussion of the philosophy of the operation of these units, the therapies given, the required interrelationships of space and a listing of specific requirements, illustrates the method proposed earlier. This is followed by a very comprehensive analysis of eight floor plans which were presented to the Veterans Administration by as many architects. These are rated as excellent, good, awkwardly operable, or unsatisfactory—with the author's reasons

for the determinations. The analysis are very well presented.

This section of the book is followed by a listing of important therapeutic and administrative principles and the relationships that must exist in psychiatric units. Although these are familiar to those acquainted with mental hospitals, they will undoubtedly prove valuable to general hospital planners as they enter a new field of specialized patient care.

The concluding chapter written by Charles Butler and Addison Erdman, Architects Associated, describes a hypothetical general hospital of about 200 beds containing a psychiatric section for both sexes.

Analytic Group Psychotherapy. With Children, Adolescents and Adults. By S. R. Slavson. 261 pages. Cloth. Columbia University Press. New York. 1950. Price $3.50.

In *Analytic Group Psychotherapy*, Mr. Slavson re-presents methods and opinions given in his other writings but, in addition, gives, in an organized manner, the dynamics of analytic group therapy as applied to children, adolescents and adults. He outlines the basic dynamics by means of numerous case records which demonstrate how resistances are reduced; how transference is acquired; how substitution is employed and how anxiety is relieved even in group settings. He advises, however, that there are certain types of persons who require individual analytic therapy as well as group.

Mr. Slavson gives specific instructions for the group therapist and emphasizes that the therapist must be a catalytic agent in the group; that he must direct group thinking and that he must make conclusive statements only in special situations. He also gives advice relative to the selection and grouping of patients. Finally, he includes a chapter on the use of group therapy for psychotic patients.

Dr. Slavson states: "Any technique that helps activate outward interest is useful here. Occupational therapy has been employed for this purpose. Spontaneous relationships on a ward were observed to be very valuable for some patients. . . . This spontaneous trend should be utilized for the activation of patients preparatory to establishing relations. Group activities are important in this connection. . . . If hospital treatment is to be considered an educational opportunity for the psychotic, patients should take an active part in groups. . . . The treatment of psychoses such as schizophrenia, depressions, manic reactions, paranoia aims mainly at strengthening the ego so that it need not retreat from reality, but rather grow able and willing to cope with it." Mr. Slavson believes that the usual method of treating psychotics in large groups is unwise since it does not allow for direct and intense interaction, as well as for transference between the therapist and members of the group.

Studies in Lobotomy. Milton Greenblatt, M. D., Robert Arnot, M. D., and Harry C. Solomon, M. D., editors, with 27 contributors. 495 pages with many illustrations, tables, an exhaustive bibliography, appendix and index. Cloth. Grune & Stratton. New York. 1950. Price $10.00.

Studies in Lobotomy is a very welcome presentation of this most timely subject. The three editors and their staff of 27 contributors give a complete review of the history and literature of this field of medicine that in a somewhat misleading terminology is called psychosurgery.

The authors cover in the first part of the book, in monographic chapters, all the fields of pre- and postoperative problems, and of the different technics of the procedure. They evaluate in detail 278 cases of lobotomy with follow-up studies from one to four years. This part of the book (pp. 87-306), containing detailed case records and statistical evaluations of every side of the problems which the lobotomy patients offer, is an inexhaustible mine of information and stimulation. These data will be indispensable for any physician who has to deal with indications for, and care of, patients who have undergone "psychosurgery."

The second part of the book contains special studies relating to physiologic and pathologic changes, and to psychologic and sociologic problems which arise and demand special management after lobotomy. The effects of the operation on the cerebrospinal fluid, on respiration and blood pressure, on secretory systems and on temperature, the relationship of the autonomous nervous system to the frontal lobes (p. 338) are demonstrated and discussed in specific chapters. It could be shown that subcortical section of the frontal lobes interferes with inhibitory and excitatory autonomic centers in the cortex, but that eventually a readjustment of the autonomic system occurs, with an autonomic equilibrium at a new level. A special chapter is devoted to the evaluation of lobotomy in regard to relief of intractable pain.

It is impossible to review in detail the wealth of information this excellent volume offers. It deserves the careful study of all physicians interested in the progress of our profession. It definitely should not be missing in any library of a hospital where lobotomies are performed. The work sheets published at the end of the book are highly recommended as a uniform basis for recording experiences for future evaluation.

The rather complete bibliography, a good index, many tables and figures, and an excellent format are additional features, adding to the value of these *Studies in Lobotomy*.

Oneirophrenia. The Confusional State. By L. J. MEDUNA, M. D. 97 pages. Cloth. University of Illinois Press. Urbana, Ill. 1950. Price $2.50.

For several years, Meduna, the originator of metrazol convulsive therapy, has investigated blood sugar variations in certain types of mental illnesses but particularly in the schizophrenias. He has reached certain conclusions which he records in this book.

According to your reviewer's understanding, "oneirophrenia" means a dreamy, confusional mental derangement. Meduna does not claim that this is specifically a type of schizophrenia, since the same reaction occurs in toxic delirious states and in manic-depressive psychoses, but he claims it is a pseudo-schizophrenic condition and that the greatest difficulty in diagnosis arises when one tries to differentiate between oneirophrenia and schizophrenia.

Meduna believes that there is a special type of mental illness (which he chooses to call "oneirophrenia"), in which biochemical abnormalities are noted during the acute stages of the illness. These abnormalities relate to carbohydrate metabolism. "The disorder of the blood sugar regulation is characterized by the following features: (1) a sustained blood sugar curve in the intravenous glucose tolerance test; (2) a positive (diabetic-like) blood sugar curve in the Exton-Rose test; (3) resistance to insulin in the intravenous insulin tolerance test; (4) the presence of a blood-sugar raising principle in the urine."

Meduna states that oneirophrenia is characterized by an acute onset, by a dreamy, confusional mental state which sometimes shows evidences of depersonalization. He claims that this condition has a good prognosis and that convulsive therapies seem to be the best treatment.

The author systematically presents his points of investigation and explains his reasons for re-evaluating the concepts of Kraepelin and Bleuler relative to dementia præcox or schizophrenia, but your reviewer believes that there will be those who will disagree. However, this book contains many provocative ideas, and suggests that further research by other investigators should be done. For these reasons every psychiatrist should read it.

The Age of Indiscretion. By CLYDE BRION DAVIS. 284 pages. Cloth. Lippincott. Philadelphia. 1950. Price $3.00.

Clyde Brion Davis has no use for the good old days, for those who sigh over their disappearance or for those who appear to seek their return in a new stratification of society. Mr. Davis points his book directly at T. S. Eliot's assertion that our period is one of declining culture and that the standards of 50 years ago were higher than ours. He sets Eliot up as a

target and proceeds to knock the stuffing out of him and out of the neo-Fascist school which holds that the world would be better with a more stratified society. This reviewer, being somewhat prejudiced against Eliot and his group, finds it difficult to say how much of what Davis strews in all directions is Eliot's natural stuffing and how much is provided by Davis. He thinks, however, that the considerable numbers of presumably cultured persons who are skeptical of the Eliot doctrines, will greatly enjoy the demolition.

Davis surveys life in the Middle West, as he knew it as a child, from schools, social customs, art, sex and literature to religion. He finds, as any other unbiased observer will, that American culture has advanced tremendously within the last half century.

Mr. Davis does not discuss the psychodymanics behind the longing for the good old days. His concern is rather with the observations and assertions of those expressing vocal preference for return to the uterus. For persons in whom nostalgia is not an emotional fixation, but who have been charmed by the recent flood of literary reminiscences, Mr. Davis' book is both delightful and highly recommended reading.

Schizophrenic Art: Its Meaning in Psychotherapy. By MARGARET NAUMBURG. 247 pages. Cloth. Grune & Stratton. New York. 1950. Price $10.00.

This is another of Margaret Naumburg's excellent and authoritative contributions to the extensive literature on art expression of the mentally abnormal. Like her other works, this volume concerns the relation of such art to therapy, a connection not generally emphasized by others. Miss Naumburg here reports on the psychodynamics of art expression in an 18-year-old and a 25-year-old girl, both severely schizophrenic. Her interpretations are primarily Freudian and are remarkably cautious. She does note the concept of the Jungian collective unconscious in connection with the archaic symbolism of some of her second patient's work. But she also notes that this patient had once wanted to be an archeologist, and the reader may draw his own conclusions.

Miss Naumburg's claims for the therapeutic value of art expression are admirably restrained. Her volume is beautifully designed and the color plates are excellent. This book should serve as a guide or handbook for either psychiatrist or artist interested in the problems of mental treatment by the use of art.

CONTRIBUTORS TO THIS ISSUE

WINFRED OVERHOLSER, M. D. Dr. Overholser, superintendent of Saint Elizabeths Hospital, federal psychiatric institution in Washington, D. C., was born in Worcester, Mass., April 21, 1892, the son of Edwin M. and Mary J. (Walker) Overholser. He received the degree of bachelor of arts, cum laude, from Harvard in 1912 and that of doctor of medicine from Boston University in 1916. In 1940, he received the honorary degree of doctor of science from Boston University. Following medical school graduation and a residency at the Evans Memorial Hospital in Boston, he entered the Massachusetts State Hospital service, remaining there from 1917 to 1936, excepting a period of military leave from February 1918 to June 1919, during which he served in the United States and in France as a psychiatrist in the Medical Corps of the United States Army.

While in the Massachusetts State Hospital service, Dr. Overholser was on the staff of several institutions and, in 1924, became assistant to the commissioner. He was director of the division for the examination of prisoners of the Department of Mental Diseases of the Commonwealth of Massachusetts from 1925 to 1930, assistant commissioner from 1930 to 1934, and commissioner of mental diseases from 1934 to December 1936. In October 1937, he became superintendent of Saint Elizabeths Hospital.

Dr. Overholser has had long experience in teaching and was on the faculty of Boston University Medical School from 1925 to 1934. Since 1938, he has been professor of psychiatry at the George Washington University School of Medicine. During World War II, he served as adviser to the selective service system and received the selective service medal. He served also as chairman of the committee on neuropsychiatry of the National Research Council. He has been prominent in numerous medical organizations, is a past president of the American Psychiatric Association, and a past president of the Academy of Medicine of Washington, D. C. He is a member of the Cosmos Club of Washington and of Sigma Xi, honorary scientific fraternity. He has been a frequent contributor to various medical and legal journals. He is editor-in-chief of the *Quarterly Review of Psychiatry and Neurology* and is a member of the National Board of Medical Examiners.

In March 1948 Dr. Overholser was awarded the Order of Al Merito by the Government of Ecuador. In August 1948, he was chairman of the United States delegation to the International Congress on Mental Health at London.

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JOOST A. M. MEERLOO, M. D. Born at The Hague, Holland, Dr. Meerloo received his medical degree from Leiden University in 1927 and his Ph.D. from Utrecht University in 1932. He received his psychiatric and psychoanalytic training in Holland, where he entered private practice in 1934. During World War II, he was chief of the psychological service of the Netherlands Army, and also served as high commissioner for welfare of the Netherlands.

Since 1946 he has been established in New York as a practising psychoanalyst. He is instructor in psychiatry at Columbia University.

He is the author of several articles and books on clinical and socio-psychological subjects.

HAROLD ZOLAN, M. D. Dr. Zolan is a staff psychiatrist at the United States Veterans Administration Hospital, Northport, N. Y. Born in New York in 1917, he received his bachelor's degree from New York University in 1938 and his medical degree from Chicago Medical School in 1943. After a year's internship at Beth David Hospital, New York City, and a residency in neuropsychiatry at Goldwater Memorial Hospital, Welfare Island, New York City, he became an army neuropsychiatrist in 1945, serving—before returning to civilian life in 1947—as assistant chief of the neuropsychiatric service and psychiatric consultant at Madigan General Hospital, St. Louis, Wash. He was staff psychiatrist at the Northport Veterans Administration Hospital from 1947 to 1949 when he joined the staff of Marcy (N. Y.) State Hospital. He was supervising psychiatrist and chief of the shock service there until his recent return to Northport.

Dr. Zolan is married and has a four-year-old son. He is a member of the American Psychiatric Association, the Association for the Advancement of Psychotherapy and other professional societies.

NEWTON BIGELOW, M. D. Dr. Bigelow is commissioner of mental hygiene of the State of New York. He is also editor of this QUARTERLY and director of Marcy (N. Y.) State Hospital. He has been inactive in both these latter positions since he became acting commissioner of the department on April 3, 1950. He was appointed commissioner on June 29.

Born in Ontario in 1904. Dr. Bigelow is a graduate of the medical school of the University of Western Ontario in 1926. He joined the New York State hospital service following a general internship and has remained with the state system ever since. He was promoted to the grade of director in 1943 and served at various times as assistant, then deputy, commissioner of the New York State Department of Mental Hygiene. He has been senior director of Marcy State Hospital since 1945 and has been editor of this

QUARTERLY since the death of the late Dr. Richard H. Hutchings on October 28, 1947. Dr. Bigelow is author or co-author of a number of scientific papers relating to personality, functional and alcoholic disorders, psychosomatic pathology, family care, shock therapy, and administration. He is a member of the American Psychiatric Association and other professional organizations. He lives in Marcy, N. Y., is married and has three daughters.

MORRIS J. TISSENBAUM, M. D. Dr. Tissenbaum has been chief of mental hygiene clinic, Brooklyn (N. Y.) Regional Office of the United States Veterans Administration since inception of the clinic in November 1947. Born in New York City, he attended school there and received his B. S. from New York University. He studied medicine in Paris where he received his M. D. in 1936. After interning at Jacksonville, Fla., and holding residencies in neurology and psychiatry at Boston City Hospital, and the Institute of Human Relations, Yale School of Medicine, he served as a psychiatrist at Danvers (Mass.) State Hospital, Rhode Island State Hospital and Norwich (Conn.) State Hospital. He served with the Veterans Administration for two years before World War II in which he was a major in the army and director of the neuropsychiatric division of the Valley Forge General Hospital. He came to his present position with the Veterans Administration after leaving the army.

HARRY M. HARTER, M. D. Dr. Harter was born in Breslau, Germany, and attended school and medical school in that city, obtaining his medical degree in 1924. He served internships and residencies in neurology at the St. George Hospital of Breslau and was in private practice in neurology and psychiatry in that city from 1926 to 1938. He was in hospital practice in Havana, Cuba, from 1938 to 1940 and psychiatrist at Marcy (N. Y.) State Hospital from 1941 to 1947. He has been assistant chief of the mental hygiene clinic, Brooklyn (N .Y.) Regional Office, United States Veterans Administration, since 1947.

IZETTE de FOREST. Mrs. de Forest has been in the non-medical practice of psychoanalysis since 1927 in New York City, Cambridge, Mass., Boston, and Marlborough, N. H. A graduate of Bryn Mawr in 1910, she was a field worker in the Connecticut Society for Mental Hygiene from 1923 to 1925. She underwent psychoanalysis and training with Sandor Ferenczi in Budapest from 1925 to 1927 and again with Erich Fromm from 1942 to 1944. A daughter and son-in-law are practising psychiatrists.

She is the author of a number of papers on psychoanalytic subjects, published in the *International Journal of Psycho-Analysis, Psychiatry, Character and Personality,* the *Journal of Clinical Psychopathology,* the *Journal of Pastoral Care* and the *Psychoanalytic Review.*

MAX COHEN, M. D. Dr. Cohen received his undergraduate training and A. B. degree from Cornell University. He was graduated from New York Medical College and interned at Beth Israel Hospital, New York City. Following this, he was resident in psychiatry at Brooklyn (N. Y.) State Hospital for two years. He is now enrolled as a student in the Columbia University Psychoanalytic Clinic for Training and Research.

LOUIS M. LIPTON, M. D. Dr. Lipton received his undergraduate and pharmaceutical training (Phm.B.) at the University of Toronto. He was graduated from medical school at the University of Toronto and then interned at St. Joseph's Hospital, London, Ontario. He served as psychiatric resident at Pilgrim (N. Y.) State Hospital for two years and at Brooklyn (N. Y.) State Hospital for one year. He is now engaged in private practice in New York City and is a student at the American Institute for Psychoanalysis.

JAN EHRENWALD, M. D. Dr. Jan Ehrenwald, now in the private practice of psychiatry in New York City, is a graduate in medicine of the University of Prague in 1925. He was associated with that university and the University of Vienna in psychiatry and neurology until 1931 when he went into private practice in neuropsychiatry in Czechoslovakia. From 1939-1945, he was in private practice as a psychotherapist in England, besides holding a number of public hospital appointments. Dr. Ehrenwald is a member of the American Psychiatric Association and other professional groups, and helped found the medical section of the American Society for Psychical Research. Before coming to this country, he was on a medical mission to Czechslovakia. He is now an associate in psychiatry at the Long Island College of Medicine.

Dr. Ehrenwald is the author of more than 50 papers on neurology, psychiatry and psychotherapy. His book, *Telepathy and Medical Psychology,* was published in New York in 1948.

HERMAN B. MOLISH, M. A. Mr. Molish received his A. B. degree from Temple University in 1936 and his M. A. from Ohio State University in 1938. At present he is completing work toward his doctorate at the University of Chicago.

He served two psychological internships at the Pennsylvania Industrial School, Huntingdon, Pa., during the summers of 1936 and 1937. From August 1938 to December 1940, he was clinical psychologist at the Ohio Hospital for Epileptics, Gallipolis, Ohio. In January 1941 he served a psychological internship with Dr. S. J. Beck at Michael Reese Hospital, Chicago, where he received his training in the Rorschach test. In September 1941, he entered the military service as a reserve officer in the navy, bureau of medicine and surgery as a clinical psychologist. While in the service, he conducted research on the psychological effects of anoxia and on the selection of aviation cadets. He performed psychological screening at various naval establishments and served as a clinical psychologist in the psychiatric divisions of several naval hospitals. In 1944 he served as a part-time research psychologist in a psychiatric study of promiscuity conducted by the San Francisco Department of Public Health.

In March 1945, Mr. Molish became chief clinical psychologist at the Mental Hygiene Clinic, United States Veterans Administration, Baltimore, Md. The present study was conducted in 1948, while he was serving as a part-time research psychologist at the Johns Hopkins University Medical School.

At the present he is on duty with the navy as a clinical psychologist at the United States Naval Training Station, Newport, R. I. Until recently he has been engaged in a research project in schizophrenia supported by Public Health grant, under the direction of Dr. S. J. Beck. He is married and has one child.

ELLEN ANNE ELSTE-MOLISH, M. A. Born in Baltimore, in 1920, Mrs. Molish received her B. S. degree in education from Maryland State Teachers College in 1942. From 1942-45, she taught elementary school in Baltimore. From 1943-45, she was a part-time graduate student in psychology at the Johns Hopkins University. She served as an assistant psychologist in the Mental Hygiene Clinic, the Johns Hopkins School of Public Health from 1944-45. In 1946-47, she was a court psychologist, Child Study Institute, Juvenile Court, Toledo, Ohio. She received her M. A. degree in psychology at Clark University in June 1947.

In 1947-48, she held a United States Public Health Research Fellowship in Clinical Psychology, Department of Preventive Medicine, the Johns Hopkins University, where she took part in the present study. Following her marriage in 1948, she acted as a part-time research psychologist at Michael Reese Hospital, Chicago.

CAROLINE BEDELL THOMAS, M. D. Born in Ithaca, N. Y., in 1904, Dr. Thomas was graduated from Smith College in 1925 and from the Johns Hopkins School of Medicine in 1930. After serving as intern and resident physician in medicine at the Johns Hopkins Hospital from 1930-1933, she studied at Harvard Medical School on the circulation of the brain, as National Research Council fellow. The following year, she returned to Johns Hopkins for research on the carotid sinus reflex in the department of physiology. Since 1936 she has been, first, instructor and, then, assistant professor of medicine at Johns Hopkins. Her past experimental work includes studies upon experimental hypertension; upon clinical hypertension; and upon prevention of rheumatic recrudescences with prophylactic sulfanilamide. During 1943-1945, Dr. Thomas was civilian consultant in infectious diseases to the surgeon general of the army. At present she is director of a study of factors which precede the development of hypertension and coronary artery disease, under the university's department of preventive medicine.

POMPEO MILICI, M. D. Born in New Haven, Conn., in 1903, Dr. Milici attended Yale University and later Cornell University Medical College, from which he was graduated in 1929. After a year's rotating internship and a year of private practice in New York City, he joined the staff of Kings Park (N. Y.) State Hospital in 1931. Since 1944 he has been first clinical director, then assistant director (clinical) at Kings Park. He is a fellow of the American Psychiatric Association and past president of the Long Island Psychiatric Society. He has contributed a number of papers previously to THE PSYCHIATRIC QUARTERLY.

Dr. Milici was married in 1930 and has two sons, both attending Cornell University.

E. Y. WILLIAMS, M. D. Dr. Williams is chief of the neuropsychiatric service of Howard University and has been head of the neuropsychiatric service of Freedmen's Hospital since 1939. A graduate of Howard University and of Howard University Medical School, from which he received his M. D. degree in 1930, Dr. Williams spent a year in externship training between St. Elizabeths and Freedman's' hospitals. From 1931 to 1933 he held a General Education Board fellowship, spent a year at the New York State Psychiatric Institute; Montefiore Hospital Neurological Institute and the Vanderbilt Clinic; and a year at Bellevue Hospital on the Cornell neurological service.

Dr. Williams has taught for 17 years at Howard University, serving in turn as instructor, assistant professor and associate professor. He estab-

lished a three-year neurological residency program there. He is a diplomate in both psychiatry and neurology of the American Board of Psychiatry and Neurology. He is a member of the American Psychiatric Association, the American Academy of Neurology, Chi Delta Mu medical fraternity, and other professional organizations. He is the author of numerous scientific articles dealing with histopathology, criminology, suicide, chronic alcoholism, multiple sclerosis and other neurologic and psychiatric subjects.

RUDOLF DREIKURS, M. D. Dr. Dreikurs is widely known as a psychiatrist, educator and writer. He is editor of *The Individual Psychology Bulletin*, and professor of psychiatry at the Chicago Medical School. He is medical director of the Community Child Guidance Centers of Chicago and is a lecturer in education at Northwestern University. He is a fellow of the American Psychiatric Association.

ROBERT L. WILLIAMS, M. D. Dr. Williams, born in Buffalo, N. Y., in 1922, was graduated from Alfred University and the Albany Medical College of Union University. He trained in neurology and psychiatry at the Albany Hospital, is now an instructor in neurology and psychiatry in the Albany Medical College, and is on the attending staff of the Albany Hospital in the department of neurology and psychiatry.

Since writing this paper Dr. Williams has been granted leave of absence from Albany Medical College and is on active duty with the United States Air Force. He is stationed at the Neurological Institute of the Columbia-Presbyterian Medical Center where he is pursuing further training as senior assistant resident in neurology.

Dr. Williams is a member of the American Medical Association and the Albany County Medical Society. He is an associate member of the American Psychiatric Association and a member of the Mohawk Valley Neuropsychiatric Society. Dr. Williams became very much interested at Albany in somatic therapies in psychiatry. He hopes eventually to continue teaching and investigational work in neurology and psychiatry and in addition to practise those specialties.

S. EUGENE BARRERA, M. D. Dr. Barrera is neurologist and psychiatrist in chief at the Albany (N. Y.) Hospital and the Albany Medical College. A graduate of the College of Physicians and Surgeons, Columbia University, in 1929, he had served in the New York State hospital system for a number of years before taking his present position in Albany. He was formerly principal research psychiatrist of the New York State Psy-

chiatric Institute. Dr. Barrera is a diplomate in both psychiatry and neurology of the American Board of Psychiatry and Neurology. He is a member of the American Neurological, Neuropathological and Psychiatric Associations and of the New York Academy of Medicine, besides other professional organizations. He is author or co-author of numerous scientific articles, including a number of previous contributions to this QUARTERLY.

NEWS AND COMMENT

ERRATA

THE QUARTERLY wishes to call attention to errors in the paper "Psychodynamic Modification of Electric Shock Treatment" by J. Robert Jacobson, M. D. in the April 1950 issue and in the paper "A Rorschach Compendium" by Zygmunt A. Piotrowski, Ph.D. in the July issue.

The timing of the electric shock noted in the last line on page 353 of Dr. Jacobson's article should be .3 to .5 seconds instead of 3 to 5 seconds. In the paper by Dr. Piotrowski, Σ c at the top of the third column of the small table on page 590 should read 2, not 12. On page 552, line 1, of the same article, the expression "less valuable" should read "less variable." The editors request subscribers to correct their copies.

FRITZ WITTELS, M. D., BIOGRAPHER OF FREUD, DIES AT 69

Dr. Fritz Wittels, psychiatrist and psychoanalyst in New York City for 30 years, died there at his home on October 17, 1950 at the age of 69. A native of Vienna and a graduate in medicine of the University of Vienna, Dr. Wittels had been a pupil and associate of Sigmund Freud for many years before coming to America. He came to this country in 1928 and again in 1929 as a lecturer on psychoanalysis at the New School for Social Research, later returning to make his residence here.

Dr. Wittels was on the staff of Bellevue Hospital during his years of private practice. He was a diplomate in both psychiatry and neurology of the American Board of Psychiatry and Neurology, was a member of the American Psychiatric Association, the American Psychoanalytic Association and other professional groups. Dr. Wittels was a widely-known writer of scientific articles. He was author of the books, ***Freud and His Time*** and ***The Technique of Psychoanalysis.*** As a young man he had written several novels.

NEW EDITION OF RORSCHACH MANUAL PUBLISHED

A new edition of The State Hospitals Press manual on the Rorschach examination has been brought out under the title of ***A Rorschach Training Manual.*** It is a revised and considerably enlarged third edition of a publication by James A. Brussel, M. D., Kenneth S. Hitch, and Zygmunt A. Piotrowski, Ph.D., first brought out in 1942 and published without a title under the headings of two articles first appearing in THE PSYCHIATRIC QUARTERLY of January 1942.

The present issue is 86 pages, paper-bound, with color illustrations of the Rorschach cards. It sells for 75 cents, a price increase from 50 cents made necessary by the enlargement of the book and materially increased costs of book publication.

The training manual consists of two articles, the first by Dr. Brussel and Mr. Hitch, describing the test, its administration, the outlines of interpretation and illustrative case material. Originally written for army use when both authors were in the service, this paper was revised for civilian purposes in 1947, and was further thoroughly revised in July of this year. This paper is illustrated by four-color reproductions of the Rorschach plates. The second paper, "The Rorschach Compendium" by Dr. Piotrowski, was written for the revision of the manual in 1947, was revised and greatly enlarged this year, and appeared in its present form in the July 1950 issue of THE PSYCHIATRIC QUARTERLY. It is a discussion of basic Rorschach theory and of the principles of interpretation, and was written for advanced, as well as beginning, students.

Two of the authors of *A Rorschach Training Manual* are connected with the New York State hospital service, Dr. Brussel as assistant director of Willard State Hospital and Dr. Piotrowski as chief clinical psychologist of the New York State Psychiatric Institute. Dr. Piotrowski also teaches at New York University and at Columbia University, where he is an associate in psychiatry at the College of Physicians and Surgeons. Mr. Hitch collaborated with Dr. Brussel on their original paper while he was clinical psychologist and Dr. Brussel was chief of the neuropsychiatric service at Fort Dix Station Hospital early in World War II. Mr. Hitch is now a consulting psychologist in Tacoma, Wash., director of research of the board of education of that city, and has served as psychologist in the Washington state hospital system.

NATIONAL MENTAL HEALTH ASSOCIATION FORMED

The National Association for Mental Health was formed in September by the merger of the National Committee for Mental Hygiene, the National Mental Health Foundation and the Psychiatric Foundation. Oren Root, New York attorney, is president of the new group and will give his full time to the duties of that position; Dr. George S. Stevenson has been elected medical director. The association, with offices at 1790 Broadway, New York City, was consolidated as the result of a special statute passed at the 1950 session of the New York legislature and signed in April by Governor Dewey. Its board of directors includes Dr. John C. Whitehorn of Baltimore, president of the American Psychiatric Association. Arthur H. Bunker, president of the Climax-Molybdenum Corporation, is chairman of the board. Staff members of the three combining organizations form

the staff of the new association. The aim of the consolidated group as explained by Mr. Bunker is to meet the same need in the mental health field as the National Tuberculosis Association and the American Heart Association meet in their fields. The three separate groups previously existing had overlapped in their work to a considerable extent.

NEW PSYCHIATRIC CRIMINOLOGY GROUP MEETS

The newly-organized Association for Psychiatric Treatment of Offenders met in June in New York, adopted a program for monthly scientific meetings except in July and August, and made preliminary plans for the foundation of a clinic for the treatment of offenders. The first fall meeting was held in September with a special meeting in October for persons interested in taking part in the clinic work. Melitta Schmideberg, M. D., is chairman of the association, and Harold R. Fox, M. D., is president.

QUARTERLY AVAILABLE IN MICROFILM FORM

THE PSYCHIATRIC QUARTERLY and the PSYCHIATRIC QUARTERLY SUPPLEMENT are now available in microfilm form to libraries, through arrangement with University Microfilms, Ann Arbor, Mich. Sales are restricted to subscribers to the regular paper editions, and film copies are distributed only at the end of volume years. The microfilms are in the form of positive film and are furnished on labeled metal reels.

Inquiries should be addressed to University Microfilms at 313 North First Street, Ann Arbor. The arrangement is intended to facilitate storage and consultation and the saving of space after regular library copies begin to show wear.

MEMORIALS FOR DR. VAN OPHUIJSEN

The *Journal of Clinical and Experimental Psychopathology* has announced that its January 1951 issue will be a memorial to Dr. Johan H. W. van Ophuijsen, director of the Creedmoor Institute for Psychobiologic Studies and internationally known psychiatrist and research worker. Dr. van Ophuijsen died in New York City on May 31, 1950 at the age of 68. A Netherlands psychoanalyst, he taught at the New York Psychoanalytic Institute from 1938 to 1948 and was formerly chief of the psychiatric staff of the Jewish Board of Guardians. He had been head of the Creedmoor Institute since its opening last winter.

The New York Psychoanalytic Society, at its 329th meeting in September, heard a memorial tribute to Dr. van Ophuijsen by Emanuel Klein, M. D. The scientific session at the same meeting was also of a memorial nature, with Edoardo Weiss, M. D. of Chicago, speaking "On Paul Federn's Contribution to Psychoanalysis."

GENERAL SEMANTICS COURSES

O. R. Bontrager, a professor of education and director of teacher training, will conduct the intensive seminar training lectures in general semantics, practice and discussion, at the thirteenth winter intensive course at the Institute of General Semantics, Lakeville, Conn. from December 27, 1950 to January 2, 1952. Enrollment is limited to 25. The special spring seminar session from April 1 to April 8 will be conducted by Professor Irving J. Lee of the Northwestern University School of Speech. The Institute's eighth summer seminar-workshop course will be conducted in August and September of 1951, and other special spring and summer courses will be announced.

15TH ANNIVERSARY OF PSYCHOLOGICAL TRAINING PROGRAM

The fifteenth anniversary of the inauguration of the New York State Psychological Intern Training Program was marked by special exercises October 20 at Letchworth Village and Rockland State Hospital. An all-day conference, arranged by Dr. Alfred M. Stanley, director of Rockland State Hospital and chairman of the committe on arrangements, highlighted recent developments in clinical psychology and problems of training clinical psychologists.

Attending the meeting, were representatives of co-operating state departments, including Mental Hygiene, Social Welfare, Correction, Education and Civil Service as well as representatives of university psychology departments and a number of former interns, many now holding important professional positions. Dr. Harold M. Hildreth, formerly a psychologist on the staff of Syracuse Psychopathic Hospital and now chief clinical psychologist, neuropsychiatry division, Veterans Administration, Washington, D. C., was chairman of the round table on problems of training.

ANALYTICAL PSYCHOLOGY LECTURE SERIES

The Medical Society of Analytical Psychology announces a six-sessions seminar next January and February on the subject "Introduction to Jungian Theory and Practice." Titles and speakers will be "Jung's Concept of the Unconscious," Dr. E. Bertine; "Basic Structural Elements of the Psyche," Dr. W. Engel; "Psychological Types," Dr. C. G. Taylor; "Jungian Dream Interpretation," Dr. B. Hinkle; "The Goal of Jungian Analysis," Dr. V. de Laszlo; "Principles of Jungian Psychotherapy," Dr. E. Harding.

The seminars, for physicians and qualified psychotherapists, will be held on consecutive Wednesdays, commencing January 10, at 8:30 p. m. The

sessions will be at the Academy of Medicine Building, 2 East 103d Street, New York City. Information may be obtained from Werner Engel, M. D., 123 West 74th Street, New York City.

SOLOMON DELIVERS SECOND HUTCHINGS LECTURE

Harry C. Solomon, M. D., professor of psychiatry at Harvard Medical School and director of the Boston Psychopathic Hospital, spoke on "Treatment of the Psychoses" at the second annual memorial lecture in honor of the late Dr. Richard H. Hutchings at the Syracuse College of Medicine, Syracuse, N. Y., on October 2. President Eugene G. Bewkes of St. Lawrence University gave a personal tribute. Members of the medical profession and medical students of Syracuse University, where Dr. Hutchings had been profeessor of clinical psychiatry, attended the lecture.

Dr. Solomon's lecture will be published in THE PSYCHIATRIC QUARTERLY, and Dr. Bewkes' tribute will also be published. The first lecture of the memorial series, "Modern Trends in Psychiatry," by Winfred Overholser, M. D., appears in the present issue. Dr. Hutchings, editor of this QUARTERLY until his death in October 1947, had been superintendent of Utica and St. Lawrence (N. Y.) state hospitals and was a former president of the American Psychiatric Association.

GROUP THERAPY CONFERENCE JANUARY 26 AND 27, 1951

The annual conference of the American Group Therapy Association will be conducted at the Hotel New Yorker, New York City, on January 26 and 27, 1951. The sessions will open with an evening meeting on January 26 at which Lewis H. Loeser, M. D.; S. R. Slavson; Florence Powdermaker, M. D., and Margaret Mead will give addresses. Three round table discussions, a luncheon, a case presentation, and the annual membership meeting will take place on January 27. Further information can be obtained from the association at 228 East 19th Street, New York 3, N. Y.

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BOOK REVIEWS

THE AMERICAN JOURNAL OF MENTAL DEFICIENCY

RICHARD H. HUNGERFORD, *Editor*

The April 1950 issue of the American Journal of Mental Deficiency includes

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